MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

ithin co-	MARYLAND STATE DE	PARTMENT OF HEALTH Sa St., Baltimore PARTMENT OF HEALTH Reg. Dist. No		
ormation carefully. The correct death clearly and legibly.	1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State. Maryland County Allegany City or town Cumberland (If outside city or town limits, write RURAL and give nearest town) Street No. 761 Fayette St (If rural, give LOCATION)		
tion h cl	How long in hospital or institution?	2.(a) It veteran, name war		
information of death clea	Mrs. Celeste Africa	None		
	4. Sex 5. Color or race B.(a) Single, married, wildowed, or divorced	MEDICAL CERTIFICATION		
IN(Female White Widowed	20. DATE OF DEATH. March 7, 19.47 219:30P.		
ERVED FOR BINDING C. Supply every item of in please write the causes	7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days It less than one day	21. I CERTIFY that death occurred on the date above stated; that I attended secessed from 19		
ARGIN RESI	77 11 24 hrs. min. 9. Birthplace	Due to		
Y, WITH UNI	14. Maiden name Adelaide Landis 15. Birthplace Penna. Mrs. A. M. Penhallow	Major findings of operations		
9-45-15M WRITE PLAINLY, is especially	207,88 Erie Rd. Rocky River 16, Ohio 17 Burial (Burial, cremation, or removal Which?) Cemetery or crematory. HillCrest Burial Park Location. Cumberland, Md.	PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, till in the tollowing; Accident, suicide, or homicide		
VS A15	18. Funeral director. Charles L. George Address Cumberland, Md. 19. March 9, 19. 47 J. P. Srawklin, M. A. Registrar (Date rec'd by registrar) Registrar	23. SIGNATURE. M. D. or other, Address. M. D. at signed. 3. J. J. J.		



correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 199-2

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Allegany	State Maryland county Allegany
City or town	
How long in above place of death?	City or town
Hospital, Institution, or street address where death occurred:	Street No. 544 Marion St.
Memorial Hospital	(If rural, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Myrtle Alderton	Kore
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Female White Widowed	20. DATE DF DEATH March 16, 19 47, 21 5: 30p.
8.(b) Name of husband or wife. Thomas F. Alderton	21. I CERTIFY that death occurred op the date above etated; that I attended deceacethrom
5.(0) Name of nusband of wife	Morch 1947 Misely 1941
7. Birth date of Table 3.0.3.00 give age	and that I last eaw h
deceaeed (mo., day, yr.) FED, 10 1005	Immediate cause of death DURATION
o. Auc.	a array
62 1 6min.	J. J
9. Birthplace Old Town Md. (Town, county, and state)	Due to
1D. Usual occupationHousewife	
	Due to
11, Industry or business	
12. Name Leonard S. Crabtree 13. Birthplace Maryland	Dther conditions
	(Include pregnancy within 3 manths of death)
H 14. Maiden name Fannie Meyers	Major findings of operations
15. Birthplace Maryland	Duling Exposes Date of op. 3/1 8/8
14. Maiden name Fannie Meyers 15. Birthplace , Maryland 16. Informant Mrs. Thelma Streett	Antopsy results.
Address 541 Marion St. Cumberland, Md.	PHYSICIAN: Please underline the cause to which death should be charged statistically.
	22. VIOLENCE: If death was due to external causes, fill in the following:
Burial Burial Date thereof Mar. 19147. (Burial, cremation, or removal, Which?)	Accident, suicide, or homicide
Cemetery or crematory HillCrest Buriel Park	Where did injury occur?
Location Cumberland, Md.	Injured at home, farm, industry, public place (where?)
	Means of injury injured at work?
18. Funeral director Charle's L. George	1000
Addgess Cumberland, Md.	23. SIGNATURE
19 March 18, 19 47 J. P. Tranklin M. D. Registrar	M. Di or other 8/4
(Date rec'd by registrar)	Address Date signed Date signed

ADING INK. Supply every item of information carefully. The or Physicians: please write the causes of death clearly and legibly MARGIN RESERVED FOR BINDING WITH UNF important. PLAINLY, is especially

especially

PLEASE

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dist.	0	2	3	0	2	,	
Dist.	N				4	4	6

walnut, mel Date signed 3.7.4

CEDTIFICATE OF DEATH

			CERTIFICAT	E OF DEATH	Reg. Diat. No		
1. PLACE OF DEATH:			,	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)			
City or town Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)				State Md County Allegany City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)			
How long In above place of dea Hospital, Institution, or street 312 N	address where de	ath occurred: Ly Terrace		Street No. 312 N. Waverly			
How long in hospital or institu	ution?			2.(a) If veleran, name war	······································		
3. (a) FULL NAME					3. (b) Social Security 1		
LeRoy Cha:	rles Al	lamong			214-05-999	99	
					ERTIFICATION	about	
male	White	Marrie	<u>d</u>	20. DATE OF DEATH March 4			
6.(b) Name of huaband or wife	Hannah	Struckman		21. I CERTIFY that death occurred on the date abo	A CONTRACT OF THE PARTY OF THE		
7. Birth date ot deceased (mo., day, yr.)	6 Augus		give ageyears	and that I last saw h im all baad.	March 4		
8. AGE: Yeara	Months		than one day	Suffocation & 3r		at	
50	5	28	hrs min.	burns	· ·	once	
9. BirthplaceCumbe	Store		•••••	Due to Over heated hot	, , , , , , , , , , , , , , , , , , ,		
11. Industry or businesa H 12. Name Willi 13. Birthplace West	lam T. A	llamong		Dther conditions			
H 14. Maiden name Mai	cy you	ng	1 ma	(Include pregnancy within 8			
16, Informant Hanns	Allamo	ng /		Autopsy results			
Address			, Cumb., Md.	22. VIOLENCE: If death was due to external ca			
Burial Date thereof 7 MAR 1947 (month) (day) (year)			Accident, suicide, or homicideAccid	lent Date of 3.	4-47 Wa		
Cemetery or crematory	Greenmo	unt Cemete	Ey	Where did Injury occur? Cumberl	(County)	(State)	
	Location Cumberland, Md.			Injured at home, farm, industry, public place (v. home burned also means of injury fir. Allamong	where?)home		
1B. Funeral directorLC		•		Deputy Medical Ca	aminer - Alle	gany Uo.	
Address Cu	umberlan			23. SIGNATUREH, V. Deming M			
1	./-	1 Phin	Whi MA	ZS. SIGNATURELLYVA.LA.SAMALLAS	M, D, 6	or other	

Registrar Address...

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legiNy. 9-45-15M PLEASE A15

MARGIN RESERVED FOR BINDING

MAR LI 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



CERTIFICATE OF DEATH

	Reg. Dist. No
2. USUAL RESIDENCE (HOME) OF D	ECEASED:
(For newborn infants give residence of mot	allegany
City or town // Midlan	dell
Street No	ite RURAL and give nearest town)
(If rural, give LOC	CATION)

2.(a)	If	veteran,	name	war

2.(a) If veteran, name war	
	3. (b) Social Security Number
	164-10-3094
MEDICAL CE	RTIFICATION
20. DATE OF DEATH Murch	13 1947 at 8A.
21. In CERTIFY that death occurred on the date above	stated; that I attended deceased from
and that I last saw h! M alive on The	ich 13 1947
Immediate cause of death Williamonsty Turling	
<u></u>	
Due to	
Due to Otterio - Seleraci	
Diher conditions	
(Include pregnancy within 3 mo	nths of death)
Major findings of operations	
	Date of op
Antopsy results	
22. VIOLENCE: If death was due to external cause	s, fill in the following;
Accident, suicide, or homicide	Date of
Where did Injury occur?(City or town)	(County) (State)
Injured at home, farm, Industry, public place (when	re?)
Means of Injury	tnjured at work?
23. SIGNATURE P. C.	M. D. or other
Address Trostleing (MA Date signed 11.5/47

correct age ADING INK. Supply every item of information carefully. The chysicians: please write the causes of death clearly and legibly UNFADING INK. PLAINLY, WITH UNF is especially important. WRITE PLEASE

1. PLACE OF DEATH

How long in above place of death?..

3. (a) FULL NAME

4. Sex

7. Birth date of deceased (mo., day, yr.)

10. Usual occupation. 11. Industry or business 12. Name.

> 13. Birthplace 14. Malden name 15. Birthplace

Address

(Date rec'd by registrar)

8. AGE:

How long in hospital or instillution?.....

Hospital, Institution, or street address where death occurred:

5. Color or race

B.(c) If alive, give age

Days

If less than one day

VS A15

HEATER TO THE PERSON STATE DESCRIPTION

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5-15M	1
VS A1	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830-

CERTIFICATE OF DEATH

	02304	
Reg. Dist. I	No8	

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give pesidence of mother)
County Co	State Many Carry County De Jan
City or town (If putside city or town limits, write RURAL and give nearest town)	Olly or form of Good on the first of
How long in above place of death? Hospital, institution, or street address where death occurred:	(If outside the or town limits, write RURAL and websites town)
Hospital, Institution, or street agrees where deal of theet	Streel No.
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
John Martin Barry	
4. Sex 5. Color or race 6.(a) Single, marged, widowed, or divorced	MEDICAL CERTIFICATION
male White Widowed	20. DATE DE DEATH. MI Arch 29 19.47 at 3.5/74 M
6.(6) Name of Ausberry or wife Matilda Elaura Plan	21. I CERTIFY that death occurred on the date above stated; that I allended deceased from
	March 2 0 18 47 10 that 2 9 1847
7. Birth data of	and that I last saw h. Sum alive on Duraceh 7. 1 19.47.
deceased (mo., day, yr.) 8. AGE: Yeers Months Days If less than one day	Immediais cause of death
74 11 23hrsmin.	Crebal timornage
9. Birtholise Ginaconing, allegary Co, Mid	Due Io
(Rowt, eounty, and state)	
10. Usual occupetion Dans National State of the State of	Due 10
11. Industry or business a flason total Co.	
12. Name Patrick Barry 13. Birthplace Earal and	Other conditions Chronic Browliab Williams
	(Include pregnency within 3 months of deeth)
14. Maiden name Thary Conly 15. Birthplace Chelana	Major findings ol operations
E 15. Birthplace Creland	
16. Informant Mrs. Garl Barry	Antopsy results
Address Grand Houra Olde	PHYSICIAN: Please underline the cause to which death should be charged statistically.
17 Busial Date thereof april 1, 194.	22. VIOLENCE: If death was due to external causes, fill in the following:
(Burial, cremation, or removal. Which?) (month) (day) (year)	Accident, suicide, or homicide
Cemetery or crematory St. Many Community	Where did Injury occur?
Location Lacquing, and	Injured at home, farm, Industry, public place (where?)
18. Funeral director Ally Cichhow	Means of Injury Injured at work?
Address Gonaconing Onds	Harry M. H. Hoda - Mil.
anil I Dur 1.4 how the morn	23. SIGNATURE AND M. D. or other
19. (Date ree'd by registrar) Registrar	Address Transfirm Date signed Meh 31 47

5 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

TARY MAKE T WIN BY ATA	DATELD .	DEL TIME	VILLA OI	TIME	104
CERTIFIC	CATE	OF	STHI	BIRT	Ħ

Reg. Dist. No.

	A certificate must be filed within 24 hours for ever	y still	birth of 20 weeks' gestation or more (see stab)
1.	PLACE OF BIRTH	2.	USUAL RESIDENCE OF MOTHER:
	County City or town The Stork (If outside city or town limits, write RURAL and give nearest town)	Ì	State Maryleine County allegany
	Street address, hospital, or/institution: Municolumn Hospital Length of mother's stay in County (How many years, or months, or days. SPECIFY WHICH)		City or town (If outside city or town limits, write RURAL and give perfect town) Street No. (If RURAL give LOCATION)
3.	Name of child Baby Boy Bell	4.	Date of birth March 13.1947 Hour 300 M.
5.	Sex Mall 6. Twin or triplet	7.	No. of weeks pregnancy 20
	Full name William anno Bell	12.	Full maiden name annu Las Johnson
9.	Color What to. Age at time of this birth yrs.	13.	Color 14. Age at time of this birth, 2 yrs.
11.	Usual occupation Machinist	15.	Usual occupation Housewife
16.	Other children born to mother (not including present child)	: (a)	How many children of this mother are now living?
2	(b) How many other children were born alive but are now de		
	Did child die before labor? No During labor? 100 Pregnancy, complications of Blanding want last Julianist Score language	21.	Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof. (a) Fetal causes Amademic Cause thereof.
19.	Labor: (a) Complications of Now (b) Induced?		(b) Maternal causes Alacenta Preserve
20.	(a) Was there an operation for delivery? (Yes or No) (b) State all operations, if any	22.	I certify to the birth of this child who was born dead on the date and hour above stated. Signature
	(c) Did child die before operation?		Address Field Will M. D., midwife or other Address
23.	(a) Bural (b) Date thereof 3-14-47 (Burial, cremation or removal) (c) Cemetery or crematory Oak Mile (month) (day) (year)	-	(a) 3-/3-47 (b) Xuu Kauly N-Rose (Registrar)
24.	(a) Funeral director LUM. James Bell	26.	(To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
	(b) Address Linal Pring, Ind		
	* See Instruction C on stub.	5.	4:

MAR 15 1947 BURFAT V B

important.

especially PLAINLY 02

PLEASE

A15 SA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

02306

County Allegany	(For newborn infants give residence of mother)	
Ecknart Md.	Stale Md. County Allega	nv
(If odeside city of town familes, write from and give nearest town)	TO a late mand	
How long in above place of death?	(If outside city or town limits, write RURAL and give near	rest town)
	Sireet No.	
Eckhart Mines, Md.	(If rural, give LOCATION)	
	2.(a) If veteran, name war	
3. (a) FULL NAME	3. (b) Social Security 1	Vumber
Albert Bender	220-10-4165	<u> </u>
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	a haut
male white married	20. DATE OF DEATH March 24 19 47	about
S.(b) Name of husband or wife Martha Ella Robinson Bend		
	19 to	
7. Birth date of	and that I last saw h im a Dead March 24	
deceased (mo., day, yr.) April 24th. I866	Immediate cause of death	DURATION
8. AGE: Years Months Days It less than one day	Coronary occlusion	at
80 II Øhrsmin.	COTOHAL, COCTASION	once
	Due to Arterio sclerosis	
9. BirthplaceGroon Ridgensy, Md. Re)	DUC 10. 22.22. M.	***************************************
10. Usual occupationRetired	B	
11. Industry or business Celanese Corp.	Due to	
	Other conditions (Found dead in bed)	***************************************
12. NameAugustus Bender	Uther conditions. L. A	
	(Include pregnancy within 3 months of death)	
14. Malden name Unknown 15. Birihplace Unknown	Major findings of operations	***************************************
15. Birihplace UIIRIIOWII	Date of op.	
16. Informant Mr. Ralph Bender	Actopsy results	
Address 6I Frost Ave. Frostburg. Md.	PHYSICIAN: Please underline the cause to which death should be charged s	tatistically.
	22. VIOLENCE: If death was due to external causes, till in the following:	
(Burial, cremation, or removal, Which?) Date thereof. 3-26-1947 (month) (day) (year)	Accident, suicide, or homicide	
Cemetery or crematory Eckhart Cemetery	Where did injury occur?	(State)
Location Eckhart, Md	injured at home, farm, industry, public place (where?)	
18. Funeral directorJacob Hafer	Means of Injury Medical Examinat Injured at work?	sauy Co
Address Frostburg, Md.	23. SIGNATURE H. V. Desiling M.D. H. Dem	
19. 3- 25 H7 Mus Maury N Rose	m. D. O	ouncy /
(Date rec'd by registrar)	Address Canada Land, Ind. Date signed 3	-24/47



PLAINLY WRITE

PLEASE

Address

PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, flil in the loliowing; Accident, sulcide, or homicide..... Where did Injury occur? (State) (City or town) (County) Injured at home, farm, industry, public place (where?) Maans of Injury 23. SIGNATURE

+2 -287 PAS Elenlas Edurand Bealight house what Thomas specifical 35 lovers in a second setter Servente C. 7.1 1-75

MARYLAND STATE DEPARTMENT OF HEALTH

02308

OPPTIPIOATE OF DEATH

CityLini		E OF DEATH Reg. Diat. No. 4	2
on carefully. The correlearly and legibly	1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Allegany City or tow RVAAL) CUMPERING AND COUNTY OF THE RUKAL and give hearest to street No. (If rural, give LOCATION) 2.(a) If veteran, name war. World War 2	own)
IDING em of information causes of death clea	3. (a) FULL NAME Frank Ellsworth Bloss 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced male white single	3. (b) Social Security Number 218-11-4445 MEDICAL CERTIFICATION a 20. DATE OF DEATH. March 12	bout
FOR BIN ly every it write the	6.(b) Name of husband or wife	Strangulation & fracture of	19
MARGIN RESERVED NEADING INK. Supp	9. Birthplace D. R. T.H. B. RANC. H A.L.L. EGAN (CD. Md. (Town, county, and state) 10. Usual occupation MIII. Ing. M.A. C. h.I. C. D. E. C. A. C 11. Industry or business GIENN MACLIN. (Outsplane) 12. Name	Due to	nce
WITTEL	13. Birtholace D. Branch And 14. Maiden name Ethel Drasy Prosmette 15. Birtholace 16. Informant Address Address	(Include pregnancy within 3 months of death) Major findings of operations	lically.
9-45-15M WRITE PI	17. (Burial, cremation, or removal. Which?) Cemetery or crematory. A arrio Ananymal Canal Location. Pol. Canal Ca	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide	-47 Md •
VS A15 PLEASE	Address Combolina 19 March 16,19 47 J. F. Tranklin, M. A. Registrar (Date rec'd by registrar)	23. SIGNATURE H. V. Deming M. D. W. M. D. or other	Jud

MAR 19 1947 BUREAU V 8

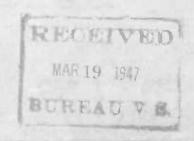
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CEDTIFICATE OF DEATH

CERTITICAT	Reg. Diat. No.
1. PLACE OF DEATH NY County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) MARYLAND County CUMBERLAND City or 10wn (If outside city or town limits, write RURAL and give nearest town) Street No. HILL CREST DRIVE (If rural, give LOCATION) 2.(a) If veteran, name war 3. (b) Social Security Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced WHITE MARRIED	MEDICAL CERTIFICATION MARCH 7, 1947 5;20 A.M. 20. DATE OF DEATH
6.(b) Name of husband or wife	21. I CENTIFY that death occurred on the date above stated; that I attended deceased from au 20
MARYLAND 9. Birthplace (Town, county, and state) HOUSE WIFE 11. Industry or business R. ROBINSON 12. Name MARYLAND 13. Birthplace	Oue to Square cell Caserrown Jacktern with generalist Due to Lymphatic metalaces Other conditions
14. Malden name EIMYRA WITHEIM 15. Birthplace MARYIAND 16. Intermant Clarence Broadwater	(Include pregnancy within 3 months of death) Major findings of operations. Date of op. Journal 30, 19 Antopsy results. Name PHYSICIAN: Please underline the cause to which death should be charged statistically.
Address 78% 4 Cumberland, Md 17. Burial, cremation, or removal, Which?) Cemetery or crematory 5% hubbers hubbers Cemetary Location Cumber land, Md	22. VIOLENCE: If death was due to external causes, fill In the following; Accident, suicide, or homicide
18. Funeral director. Ather S. S. F. Franklin, M. D. (Date rec'd by registrar)	Means of Injury Injured at work? 23. SIGNATURE When Jaw St. M. D. or other Address Substitution St. Bate signed May 1,199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age MARGIN RESERVED FOR BINDING



WRITE]

PLEASE

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



02310

Reg. Dist. No.

1. PLACE OF DEATH: County Allegany				2. USUAL RESIDENCE (HOME)	OF DECEASED: f mother)	
Cl-anland				state Laryland c		r
City or town(If outs	ide eity on town lin	nite write R	IIRAL and give negrest town)	City or town. Cumberla		
How long in above place of	death?	43 16	ears			
Hospital, Institution, or str	eet address where d	eath occurred		Street No. 211 Carroll S		
					ve LOCATION)	
	titution?			2.(a) If veteran, name war		
3. (a) FULL NAME					3. (b) Social Securit	ty Number
			eida Bromery		None	44
4. Sox 5	. Color or race		, married, widowed, or divorced	MEDICAL C	CERTIFICATION	
Female	Colored		Married	20. DATE DE DEATH. Larch	31 19 47	, at 11- P
B.(b) Nams of husband or	Rar	ndolph	Bromery	21. I CERTIEY that death occurred on the date a	bove stated; that I attended do	eceased from
		B (e	thalive give age vess	97c.	145 10 Mar	31 19.4.1
7. Birth date of	James	ry 24	:) If alive, givo ageyear			
decossed (mo., day, pr.) 8. AGE: Years	Months	Days	It less than one day	Immediate cause of death		
o. Ada.	2	7	hrs. min	amoroshie la	4-00	
43	1			Chayopophie Ka	in	34
9. Sirthplace. Cumbe	rland, Al	Llegany	Co, Maryland	Due to	£.5	JAGAS
10. Usual occupation	F	louse		Duo to	***************************************	
11. Industry or business		99				
H 12. Kame	Ro?	bert Ed	lmondson	Other conditions	[\$40400000******************************	
12. Name		Paw Pay	v. W. Va.			
			ver	(Include pregnancy within		
14. Maiden name				Major findings of operations	************************************	
			ld, W. Va.		Date of op	
16. Informant	Randolph	n Brome	ery	Antopsy results	1.1 1 1 1 1 1 1 1 1 1 1 1	J. a. status III
Address 211 C	arroll St	t. Cum	berland, Md.	PHYSICIAN: Please underline the cause to		ed statistically.
			4/3/47 (month) (day) (year)	22. VIOLENCE: It death was due to external c		
(Burial, cremation, of	removal, which;)			Accident, suicide, or homicide		
Cemetery or crematory.	nose		Cemetery	Where did injury occur?(City or town		
Location	Cum	berland	i, lid.	Injured at home, tarm, Industry, public place	(where?)	
19. Funeral director	Will	iam H.	Kight	Means of Injury	Injured at work?	/
Address			nd, Md.	- anther +	Jones m.	۶.
16.02	47	0 ×	Landin m D	23. SIGNATURE	1/ M.	D. or other
19 A Lawrence Beginstrage				110 S. Centre 21	Date sign	ed 4-1-47



2411 N. Chai	DEPARTMENT OF HEALTH rles St., Baltimore 93-70 TE OF DEATH Reg. Diat. No.
1. PLACE OF DEATH: County City or town (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, Institution, or street address where dearn occurred:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State. County. City or town. (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION)
3. (a) FULL NAME Mary Eller Bryan	3. (b) Social Security Number
4. Sex 5. Color er race 6.(a) Single, married, widowed or divorced	MEDICAL CERTIFICATION 20. DATE OF DEATH. March 6 19 47 21 10:15
8. AGE: Yssrs Months Days If less than one day 50 9 29 hrs. mir 9. Birthplace Slaw Months (Town, county, and state) 10. Usual occupation Monte week 11. Industry or business Bear Konec 12. Name Edward O'Breau 13. Birthplace Skalland	Due to Ducker Special Duration
14. Malden name Wary & Eleu Byrnes 15. Birthpiace Milland Mid. 16. Informant Stelliein O. Bryan Address Luke Maryland	(Include pregnancy within 3 months of death) Major findings of operations. Date of op. Antopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.
(Burial, cremation, or removal Which?) Cemetery or crematory Location Location Date thereof (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Address **Westernsort, Ned. Description Property Property	23. SIGNATURE Jane 40 Cloentholor M. D. orgelle

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WITH UNFADING INK. Supply every item of information carefully. The correct important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CEPTIFICATE OF DEATH

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CERTIFICAT	Reg. Dist. No.
1. PLACE OF DEATH: County (If outside city or town limits, write RURAL and give nearest town) How iong in above place of death? Hospital, institution, or street address where death occurred:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State
How long in hospital or institution?	2.(a) If veteran, name war.
3. (a) FULL NAME Clasaleth Veron 4. Sep 5. Color or race 6. (a) Single, married, widowed, or divorced Finale Nate Nation	3. (b) Social Security Number April MEDICAL CERTIFICATION 20. DATE OF DEATH. DATA 16 19 4 7 21 9 5 4.
6.(b) Namo of hueband or wife James Bryson	21. I CERTIFY that death occurred on the date above etated; that I attended deceased from
7. Birth date ot deceased (mo., day, yr.) 8. AGE: Years Monthe Days It loss than one day hrs. min.	and that I last saw h. A. alive on 14 non 19. Immediate cause of death Modesstrial 7 unit 4 and 4
9. Birthplace Mesters (Town county, and state) 10. Ueual occupation. however.	Oue to Camp & Cype of alore 2 et detapmed: Ouo to.
11. Industry or busines 12. Name	Other conditions describe Tolling Toll 2 years. (Include pregnancy within 3 months of death)
14. Maiden name Besser Mac Famlane 15. Birthplace Sulumb	Majar fiadiags af aperationa Nove dose
16. Informant Samue Brigaria	Aatapsy results. 2017 PHOSE PHYSICIAN: Please underline the cause to which death should he charged statistically.
17. Date thoreot. Mar. 19, 1947 (Burist, cremation, or removal, Which?) P. F. J. Co. (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following; Accident, euicide, or homicide
Cemotery or cromatory Samuel Ma	(City or town) (County) (State)
18. Funeral director Louis Stein Inc	Means of injury Injured at work?
Addrees Cumbinly	23. SIGNATURE W. alfel Va Dene
19. March 18, 19 47 J. F. Franklin, M. D. Registrar	Address Cunferland, mv. Bato eigned 18 mor47

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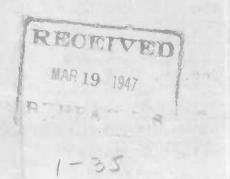


MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

2411 N. Char	DEPARTMENT OF HEALTH Arles St., Baltimore 734 ATE OF DEATH 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Maryland County Allegany City or town Cumberland, (If outside city or town limits, write RURAL and give nearest town) 130 Grand Ave., (If rural, give LOCATION) 2.(a) If veteran, name war.		
1. PLACE OF DEATH: County			
BRUCE CHESNUT	3.(b) Social Security Number 705-09-7939 MEDICAL CERTIFICATION		
Male White Single Single	MEDICAL CERTIFICATION / / 2D. DATE OF DEATH Mar. 13, 1947 at 1:00P		
8. AGE: Years Months Days If less than one day Nor. 8. AGE: Years Months Days If less than one day Nor. 67 3 12 Nor. 9. Birthplace Treight Conductor 10. Usual occupation B. & O. Railroad	21. I CERTIFY that death occurred on the date above stated; that I attended deceared from 19 19 19 19 19 19 19 19 19 19 19 19 19 1		
12. Name George Chesnut 12. Name Penna.	Other conditions (Include pregnoncy within 3 months of death) Major fiediogs of operations. Date of op.		
16. Informant Mrs. Alice Hauger Address 130 Grand Ave. Cumberland, Md. 17. Burial Date thereof Mar. 15,1947 (Burial, cremation, or removal, Which?) Rose Hill	Actorsy resolts		
Cemetery or crematory Location Cumberland, Md. 18. Funeral director Charles L. George Address Cumberland, Md.	Injured at home, farm, industry, public place (where?) Maens of injury Injured at work? 23. SIGNATURE. ADD GRAND SUBJECT (MD). or other (MD).		



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MARYLAND STATE DEPARTMENT OF HEALTH

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9				4	(1)
	Reg.	Diat.	No		

1. PLACE OF DEATH: County ALIF GANY		2. USUAL RESIDENCE (HOME) (For newborn infants give residence of	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)			
City or town CUMBERIAND	imits, write RURAL and give nearest town)	state WEST VIRGINIA C	State WEST VIRGINIA COUNTY HARDY			
(If outside city or town		City or townMOOREFIELD	its write RIIRAL and give nearest town)			
Hospital, Institution, or street address where	death occurred:	Street No.				
MEMORIAL HOSPI	1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 1 1 1 1 1	(If rural, gi	ve LOCATION)			
How long in hospital or Institution?	TE DATE	2.(a) If veteran, name war				
3.(a) FULL NAME MRS. BETTIE W	- CHRISMAN		3. (b) Social Security Number			
4. Sex 5. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL (CERTIFICATION			
FEMALE WHITE	WIDOWED	20. DATE OF DEATH MARCH 2	19 47 10:451			
6.(b) Name of husband or wife		21. I CERTIFY that death occurred on the date a	above stated; that I attended deceased from			
7. Birth date of 1. /01. /	yei	and that I last saw halive on	19.47			
deceased (mo., day, yr.) 4/24/. 8. AGE: Years Months	Days If less than one day	Immediate cause of death	DURATION			
91 /0	8m	in.				
9. Birthplace WEST VIRGIN	ra .	Due to Franchisco	1 Jelma			
(Town	county, and atate)		<i>Q</i>			
	.A.	Due to Tall	hand.			
11. Industry or business MORTIMER G	MBLE					
12. Name MORTIMER GA		Dther conditions				
	LCUNNINGHAM	(Include pregnancy within				
Handler name ELIZABETI 15. Birthplace VIRGIN		Major findings of operations				
MEMORIAI, HOS		Aotopsy results	Date of op.			
OLDATA TARES	***************************************	PHYSICIAN: Please underline the cause to	which death should be charged statistically.			
00	m-1 11 11-194	22. VIOLENCE: If death was due to external o				
(Burial, cremation, or removal, Which	Date thereof	Accident, suicide, or homicide				
Cemetery or prematory Olice	1:00 10	Where did injury occur?(City or town	(County) (State)			
Location	refield - 11-00	injured at home, farm, industry, public place				
18. Funeral director P. E. Ole	Epish & Van	Msans of Injury	Injured at work?			
Address Mo	orelield - 7- Va	- W	4. gracel			
Me //	1) 14. 11. Su 1	23. SIGNATURE	M. D. or other			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and least the causes of death clearly and least the cause of death clear the cause of death clear the cause of death clearly and least the cause of death clearly and least the cause of death clear the clear the cause of death clear the clear the clear the cause of death clear the clear the clear the clear

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02315 Reg. Dist. No. 4

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infarts give residence of mother)
County Charles Charles	State narmand County allegany
City or town(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?	(If outside city or town limits, write RURAL and give nearest town)
hospital destitution, or street address where death decumed.	Sireet No. 207 10 Lift rupt, give LOCATION)
How long in hospital or institution?	2.(d) It veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
mystle may Cli	ne More
4. Sex 5. Color or race 6.(a) Single, married, wigoved, or divorced	MEDICAL CERTIFICATION
Yamle White Single	20. DATE OF DEATH MACA 17 1947 21 12
6.(b) Name of husband or wife	21. I CERTIFY that dealh occurred on the date above stated; that I attended deceased from
	19 10 19
7. Birth date of deceased (mo., day, yr.) Proper 25 A46	and that I last saw h
8. AGE: Years Months Days If less than one day	Immediais cause of death
O 8 22hrs.	in.
8. Birthplace Cumberland, mg	Due to.
(Town, county, and state)	
10. Usual occupation	Oue to
11. Industry or business	
12. Name	Dther conditions
	(Include pregnancy within 3 months of death)
14. Maiden name Many Danier 15. Birthplace Wellstong W. V.	Major fieldings of operations
2 15. Birthplace Wellalows W.V.	Date of op.
16. Informant	Autopsy results
Address 207 Refford Sy Crembuland, My	
Date thereot 19 Mar 1947	22. VIOLENCE: It death was due to external causes, fill in the following: Accident, suicide, or homicide
(Burial, cremation, or removal. Which?) Date thereot	
Cemetery or crematory	Where did injury occur?
Location Charles And Andrews	Injured at home, tarm, Industry, public place (where?)
18. Funeral director	Means of injury Injured at work?
Address Cumbalant M.	- White Saming M. D.
March 19.47 AP tranklin M.	23. SIGNATURE M. D. or other
19. Markett (1914) (Nauktur Ma)	rar Address Combestand Med Date signed 3/18/

MAR 25 1947 BERLAU 3 and

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baftimore (55-0)

CERTIFICATE OF DEATH

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		CERTIFICA	IL OI DEATH	Reg. Diat. No.		
County			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mothed) State WEST VIRGINIA County Marketteller (ity or town KEYSER (if outside city or town limits, write RURAL and give nearest town			
How long in above place of deat Hospital, institution, or street		eath accurred:				
MEMORIA	L HOSP	ITAL	Streef No. RT. 2 BOX			
How long in hospital or institu				Joeanon)		
	tion?		2.(a) If veteran, name war			
3. (a) FULL NAME	٤.			3. (b) Social Security Number		
MR. ELMER	COATE	S		None		
4. Sex 5. Co	ior or race	6.(a)Single, married, widowed, or divorced	MEDICAL CE	RTIFICATION		
MALE W	HITE	MARRIED	20. DATE OF DEATH MARCH 24	10 47 . 3		
	BAT NINT T	7/ 1/2:				
6.(b) Name of husband or wife			21. I CERTIFY that death occurred on the date about 17 19.5			
***************************************		6.(c) If alive, give age74 years				
7. Birth date of deceased (mo., day, yr.)	TIT.Y 1	8, 1878	and that I last saw halive on			
	Months	Bays If less than one day	Immediate cause of death			
0. AGE.	X	/		om A.		
68	0	hrsmin.	- Unimory ALLE S. Handle Larum			
9. Birihpiace	V I HULL	ounty, and atate)	R Due to Duration : Opproxima	tely six months.		
		V		ClubG.		
10. Usual occupation FARMER			Due to Both exillary regions	showed adenopathy.		
11. Industry or business . m / n			Skin metastased men ante	ion left chest-wall.		
E 12 Name BEN COATES			Other conditions. Obdomen, negatines.			
13. Birthplace	an area are	A Kennseelvania				
	777		(Include pregnancy within 3 m	nonths of death)		
14. Maiden name	INDA HA		Major findings of operations Positive Biopsy			
14. Maiden name	PENNSYI	JVANIA		Oate of op		
	MORTAL	HOSPITAL	Antoney results NOT DONE	: no outopsy		
70.1110.1110.11		ND. MD.	PHYSICIAN: Please underline the cause to wh	ich death should be charged statistica		
Address, Ut	MDEVTY	71. 1. 1. 0.1-	22. VIOLENCE: If death was due to external cau	ses, fill in the following;		
17 Bushale		Date thereof MACM 2(0,1 (Year))	Accident, suicide, or homicide			
Cemetery or crematory Missipal Daglish Charge Chi			(City or town)			
Location RK. 22 Keyser, W. 14.			fnjured at home, farm, industry, public place (wi	ere?)		
an round division M	_ / /		Means of Injury	injured at work?		
		ERS,	1	7 n m 1		
Address KEYSE	R, W.J	A	23. SIGNATURE.	Carley 11. W		
10 March 25	5 10 47	&. P. Ovank him M. L	Dec 1 Hout	M. D. or other		
(Date rec'd by registrar) /	Registral	Address. Mesarred	Date signed 2/2		

information carefull of death clearly and item of i MARGIN RESERVED FOR BINDING ADING INK. Supply every in Physicians: please write the

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M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83.0

/			CERTIFICA	TE OF DEAT	ГН	Reg. Di	at. No	4	
1. PLACE OF DEATH: County			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State						
How long in hospital or	Institution?		***************************************	2.(a) It veteran, name w	2.(a) It veteran, name war				
3. (a) FULL NAM	E Her	nry W.	Connor			220-1	O-0568A		
4. Sex	5. Color or race		e, married, widowed, or divorced		MEDICAL C				
Male	White		Married	20. DAYE OF DEATH	March	10	19. 47	3 A M	
7. Birth date of deceased (mo., day,)	r.) Augi	6.0	c) It allve, give age	21. LOERTIFY that death	10 11	ayeh, E	carch !	0 19.4.7	
8. AGE: Years		Days	If less than one day	Hems					
	(10wn, e	ounty, and		Due to Ach	erio So	leroz	16		
10. Usuai occupation	Pressure	a Oper	ator	Que to					
11. Industry or business	. Cumberland	1 & Al	legany Gas Co		A		- pot		
	Thomas	3 Conn	or	Other conditions.	woned	procla	Rekis	***************************************	
		otland		(Inclu	de pregnancy within	3 months of death)			
HLOW 14. Maiden name	Janet	Carle	<u> </u>	Major findings of oper	ations	108800000000000000000000000000000000000			
15. Birthplace	Sc	otland	<u> </u>						
	Miss Ber			Autopsy results PHYSICIAN: Please u	nderline the cause to	which death should	he charged at	tatistically.	
17Bu	rial	Date ther	reol 3/12/47 (month) (day) (year) Cemetery	22. VIOLENCE: It dea Accident, suicide, or ho Where did Injury occur	omicide		Date of	(State)	
	Namb							******************	
Location			kight	Means of Injury			at work?		
18. Funeral director	Cumber				Il on	Res		127,00	

P. Franklin

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The consession is especially important. Physicians: please write the causes of death clearly and legibly. 9-45-15M VS A15

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	(For newborn infants give residence of m	nother)	
	State MA Coun	, allogous	
	City or town	write RURAL and give nearest town	
-	1 Was	CCATION)	
	2.(a) It veteran, name war		
	. 0	3. (b) Social Security Number	
,	orick	220-03-7584	7
ĺ	MEDICAL CE	RTIFICATION	
	20. DATE OF DEATH Mar 20	19 4.7 at 8:30/	F
ı	21. I CERTIFY that death occurred on the date above		
l		La 10 Trease 20 19 17	P
	and that klast saw h = 1 alive on		
	and the second s	A DUBLETON	
	Immedia canogo death when fulfire	wons syear	_
	Due to diabrtes mellis	6/year	•
	Due to the 12 723 facelly	425	
	Oue to		
	Other conditions		• •
	(Include pregnancy within 3 m	ontha of death)	
	Major findings of operations		
		Date of op	
	Antopsy results	ch death should he charged statistically.	
	22. VIOLENCE: If death was due to external caus	es, fill in the toliowing:	
	Accident, suicide, or homicide		
	Where did injury occur?(City or town)	(County) (State)	
	injured at home, tarm, industry, public place (who	ere?)	
	Means of Injury	Injured at work?	_
	(14)	James he. S.	
	23. SIGNATURE CASCULAT	M. D. or other	

1 7 1 534 Bundary 534 Buch con Three Mand Joseph Gernielle RECUIVED MAR 25 1947 the termination of Therman Hand Holl It le Thomas works The Commerce Herminger 16. 70-Somet I device Aller Strates

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICAT	TE OF DEATH Reg. Diat. No.
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State County City or town (If outside city or town limits, write RURAL and give nearest town) Street No. (If roral, give LOCATION) 2.(a) If veteran, name war.
3.(a) FULL NAME Stephen Corrott	3. (b) Social Security Number
4. Ses 5. Color or race 6.(a) Single, married, widowed, or divorced Sugge 5.(b) Name of hueband or wife.	20. DATE DF DEATH
7. Birth date of deceased (mo., dey, yr.) 8. AGE: Yeare Months Days If less than one day	and that I last saw b 19.7 10 19.7 Immediate cause of death DURATION
9. Birthpiace	Due to. Actenosolaros
11. Industry or businese 12. Name	Other conditions
Address 513 & Park are - Farmont W. Va	Aatapsy results PHYSICIAN: Please underline the cause to which death shauld be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide
Date thereot (month) (day) (year) Cometery or crematory Zion Memorial Park Location Comber land, Md.	Where did Injury occur? (City or town) (County) (State) Injured at home, tarm, Industry, public place (where?)
18. Funeral director	Meane of Injury 23. SIGNATURE. M. D. or other Address Oate slened Oate slened

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2411 N. Charles St., Baltimore (872)

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U.E.K	1111	LA			Dr.A	

	Reg. Dist. No.
1. PLACE OF DEATH: County City or town. (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Couoty Town (if outside city or town limits, write RURAL and give nearest town) Street No. The Arc. (If rurol, give LOCATION) 2.(a) If veteran, name war.
3. (a) FULL NAME Baby Girl Cnabtree 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced Single	3. (b) Social Security Number MEDICAL CERTIFICATION 20. DATE DF DEATH MARK / 7 1947 21 21
7. Birth date of deceased (mo., dsy, yr.) 8. AGE: Years Months Days It less than one day Months Months	21. hCERTIFY that doth occurred on the date above stated; that I attended deceased from 19.4 to the state of the state on 20. Immedia is cause of death. DURATION
9. Birthplace	Due to
12. Name. Leo Crastree 13. Birthplace Comberland, Md 14. Malden name. Alberto Little 15. Birthplace Comberland, Md 16. Interment. Alegony Hospital	Other conditions
Address Compactory, March 17 Barian Bate thereot. Jares 18, 1947 (Burial, cremation, or removat. Which?) Cemetery or crematory. Green mount concertory Location. Cal. Mar. Sept. 22, 44	22. VIOLENCE: It death was due to external causes, till in the tollowing;
18. Funeral director forting for the first and 215d. 19 March 18, 1947 J. P. Franklin, M. D.	23. SIGNATURE By My Schuller My My D. or other W. By Schuller W. Bate Schull F. (24)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The is especially important. Physicians: please write the causes of death clearly and legibly MARGIN RESERVED FOR BINDING

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MAR 25 1947 2-35

1. PLACE OF DEATH	d: Y		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
Ounty CUMBERIAND One of the first of the control o			State PENNSYLVANIA County SOMERSET
			Street No
		OURS 30 MINUTES	2.(a) If veteran, name war
3. (a) FULL NAME			3. (b) Social Security N
BABY F	OY DEAL		NONE
4. Sex 5	. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION
MALE	WHITE	SINGLE	20. DATE OF DEATH
6.(b) Namo of hueband or			21. I CERTIEY that/death occurred on the date above stated: that I attended decease
	,		ears and that I last eaw h. I. Malive on 3 / 4 6 / 4
7. Birth date of deceased (mo., dey, yr.)	3-26-),7	Immedia; cause of death.
8. AGE: Years	Monthe	Daye If less than ooe day	000
	_	3hre30rr	min. Pulmonery aleedes
9 Rirthniace CIN	BERLAND	ALLEGANY, MARYLAND	Oue to.
10. Usual occupation	NEMBORU		Oue to
11. industry or bueineee	•		Other conditions
至 12. NameDEAL	PENNA		
12. NameDEAL			(Include pregnancy within 3 months of death)
12. NameDEAL	IVENGOOD	, MARY ELIZ	
12. NameDEAL 13. Birthplaco		, MARY ELIZ	(Include pregnancy within 3 months of death) Major fiedings of operations
12. NameDEAL 13. Birthplaco 14. Maiden name	IVENGOOD	, MARY ELIZ	Major fiedings of operations
12. NameDEAL 13. Birthplaco 14. Malden nameI. 15. Birthplace 16. Informant	IVENGOOD	MARY ELIZ	Major fiedings of operations
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12. NameDEAL 13. Birthplaco 14. Malden name	PENNA	Date thoroof. Mad 27-194.	Major fiedings of operations

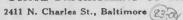


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MARYLAND STATE DEPARTMENT OF HEALTH





CERTIFICATE OF DEATH

/	Reg. Dist. 100
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County DI Alland	11 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
City or town (If outside city or town limits, write HUKAL and give nearest town)	101 1 0 0 0 5 16 4
How long in above place of death?	City or town (If outside city or town limits, write RURAL and give nearest town)
Hospilal, Institution, or street address where death occurred:	Sireet No.
L	(If rural, give LOCATION)
How long In hospital or Institution?	2.(a) If velèran, name war.
3. (a) FULL NAME. Virginia Stone Densmor	3. (b) Social Security Number
4. Sex V. Color or race (8.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Genale Midowed	20. DATE OF DEATH. March 22 19.47, 21.44 A.M.
6. (b) Name of hyaband or with David It. Densmure	. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
	March 20 1947 10 brack 22 19 42
7. Birth date of // / / / / / / / / / / / / / / / / /	and that I last eaw h
deceased (mo., day, yr.) 8. AGE: Years / Months / Days If less than one day	Immediate cause of death
89 8 16min.	Cerebral Hesson May 2
12	
9. Birthplace. (Town, county, and state)	Due to
1D. Usuat occupetion Armsennik	Due to
11. Industry or bueinese One home	
12. Name Sagur Stare	Diher conditions
13. Birthplace / auknown	
14. Maiden name, Chin. Aubbe	(Include pregnancy within 3 months of death)
15. Birthplace Quikning	Major findings of operations.
15. Birthplace Win Newword	
16. Informant La Caste Manual and aff	Autopsy results
Address	22. VIOLENCE: If death was due to external causes, fill in the following:
(Burial, cremation, or removal. Whigh?)	Accident, sulcide, or homicide
Cemelery or crematory Allagaria Carretting	Where did Injury occur?
	Injured at home, farm, Industry, public place (where?)
Location Location Location	Means of Injury Injured at work?
18. Funeral director.	,
Address maring life	23 SIGNATURE HARRY M- Hodgson MA
3/21- 1 47 Januartam Boal	M. D. or other
(Date rec'd by registrar) Registrar	Address Date signed With 2.3. 4.7.

APR 1 1947

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERT	ICIC	ATE	OF	DEA	TH
C.F.R.I	IFIC	AIL	Ur	DEA	

g. Dist. No.

		CERTIFICAT	E OI DEATH	Reg. Dist. No.
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) 0 (For newborn infants give residence of	F DECEASED:
CountyA.L.I.E.G.	ANY	•••••••••••••••••••••••••••••••••••••••		
City or townCUMBER	LAND	MARY TAND	State MARYLAND Cou	ALLEGANY
		HEAVS	City or town(If outside city or town limit	EN CUMBERLAND, Keeker, write RUBAL and give near set town)
How long in above place of death Hospital, institution, or street	address where d	eath occurred: // / /	P+ 1= 16	owling Green
		ORIAL/Kospilal	Street No. (If rural, give	
How long in hospital or institut	tion? 20	DAYS /	2.(a) if veteran, name war	
O C . PRILLY MARKET	lenry			3. (b) Social Security Number
PHILLIPI				More
	ior or race	6.(a) Single, married, widowed, or divorced	MEDICAL CI	ERTIFICATION
MALE	NHITE	MA RRIED	20, DATE OF DEATH MAR. 29	147 at 1:30 B
	TO TONING TO	NOTON TITTA	21. I SERTIFY that death pepurred on the date abo	on stated; that satisfied deceased from
6.(b) Name of husband or wife.		NGTON, ELLA	Tret DO 1 4	10 19/
T. Birth date of		6.(c) If alive, give age6.7years	and that I last saw he alive o	earthago 1941
deceased (mo., dsy, yr.)	eptem be		Immediaic cause of death	DURATION
8. AGE: Years	Months	Days If less than one day	Coveres	rug
72	6	18min.	andros	tob.
W	.VA.	Colhoun Co.	Due to	
9. Birthplace	(Town, e	Calhoun Co.		
1D. Usual occupation	Retired	<u> </u>	Due to	
11. Industry or business Tib	n MiH	worker	Due to	
	rick	Dovine	Other conditions	
12. Name	Ivelan	,		
		Simmons	(Include pregnancy within 3	months of death)
14. Malden nameE	_		Major findings of uperations	***************************************
	Frano			Date of op
16. Informant G/e	nn De	vine	Autopsy results	
Address R+#5		berland, Md.	PHYSICIAN: Please underline the cause to w	
			22. VIOLENCE: If death was due to external car	
11. (Burial, cremation, or rer	moval, Which?)	Date thereof April (day) (year)	Accident, suicide, or homicide	Date of
Cemetery or crematory	il/ Crest	Cometery	Where did injury occur?(City or town)	(County) (State)
0 1		Maryland	Injured at home, farm, Industry, public place (w	where?)
LOCATION	0 1		Msans of Injury	in, and at work?
1B. Funeral director	John	, Vaço	8 (00	(-0)
Address (v	mberla	n.V. M.d.		grand .
Ah il	1 47	I. P Frankle. M.	Y.S. SIGNATURE	O _ M. D. or other
19. (Date rec'd by registrar	1.19.4.	Registrar	Code Comments	C. bale signed

APR 5 1947
BURLAU V B

PLAINLY, WITH UNFADING INK. Supply every item of information carefully is especially important. Physicians: please write the causes of death clearly and

PLEASE

VS A15

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-0

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02324

CERTIFICATE OF DEATH

Reg. Dist. No. 40

	Kog. Diate No		
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
Cumberland	State Maryland County Allegany		
Jity or town	Combonland		
How tong in above place of death?	(If outside city or town limits, write RURAL and give nearest town)		
Hospital, Institution, or street address where death occurred:	Street No. 133 Paca St.		
Allegany Hospital	(If rural, give LOCATION)		
How long to hospital or Institution?	2.(a) If veteran, name war		
3. (a) FULL NAME	3. (b) Social Security Number		
DARLENE MARIE DICK	None		
Female 5. Color or race 6.(a)Single, married, widowed, or divorced Infant	MEDICAL CERTIFICATION		
remaie will be intail	20. DATE DF DEATH Mar. 25, 19 47 , 21		
	21. I CERTIFY that death occurred on the date above stated; that J attended deceased from		
6.(b) Name of husband or wife	Moral 23 1997, 10 March 25 19 9		
T. Birth date of Mar. 23. 1947	and that I last saw h. L. alive on Music 2 5 19 4		
Geceased (mo., day, yi.)	Immediate cause of death		
0. 1.62.	filmsture bely 3dogs		
0 2min.	A		
9. Birthplace Cumberland, Md. (Town, county, and state)	Due to blacuto preva		
(Town, county, and atate)			
10. Usual occupation	0.4-		
11. Industry or business	Due 10		
≝ 12. Name John Dick	Other conditions.		
E 13. Birthplace Westernport, Md.			
El 13. birinpiace Westerrigor G. Pict.	(Include pregnancy within 3 months of douth)		
E 14. Malden name Loma May Sowers	Major fiediogs of operations		
14. Malden name Loma May Sowers 15. Birthpiace Thomas, W. Va.	Date of op.		
16. Informant Mr. John Dick	Autopsy results.		
TV. III STILLER	PHYSICIAN: Please noderline the cause to which death should be charged statistically.		
Address 133 Paca St. Cumberland, Md.	22. VIOLENCE: If death was due to external causes, fill in the following:		
Burial Burial (Burial, cremation, or removal, Which?) Date thereof Mar. 26, 1947 (month) (day) (year)			
(Burial, cremation, or removal. Which?) (month) (day) (year)	Accident, suicae, or nominate		
Cemetery or crematory Rose Hill Cemetery	Where did injury occur?		
Location Cumberland, Md.	tnjured at home, farm, Industry, pub ¹¹ c place (where?)		
1B. Funeral director Charles L. George	Misans of Injury Injured at work?		
Address Cumberland, Md.	(Milion MI)		
mand 1 in a Detail on X	23. SIGNATURE		
(Date rec'd by registrar) 1947 X. F. Dauklin, M. D. Registrar	Address Delene 87, Date signed 3-26-9		



Within corporate limits DR. WILSON MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles St., Baltimore CERTIFICATE OF DEATH Reg. Diat. No ... 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother) County ALIEGANY State MARYLAND County ALLEGANY City or town. FROSTBURG.
(If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 18 DAYS Hospital, Institution, or street address where death occurred: information care 120 FROST AVENUE MEMORIAL HOSPITAL (If rural, give LOCATION) How long in hospital or institution?..... 2.(a) If veteran, name war..... 3. (a) FULL NAME 3. (b) Social Security Number DIEHL MARY E MRS
S. Color or race | 5.(a) Single, married, widowed, or divorced NONE MEDICAL CERTIFICATION BINDING MARRIED 6.(b) Name of husband or wife DIEHL RUSSELL C. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6.(c) If alive, give age 55 years 7. Birth date of 9-18-90 deceased (mo., day, yr.) DURATION If less than one day 8. AGE: RESERVED 56 6 13 HOUSEWIFE fD Heugi occupation..... MARGIN ff. Industry or business 單 12. Name LAYMAN GEORGE MARYLAND ₹ 13. Birthplace (Include pregnancy with a 3 months of death) # 14. Maiden name CROWE, LOU 2 15. Birthplace MARYLAND MRS. ROBERT WILSON. especially 16. Informant... PLAINLY PHYSICIAN: Please underline the cause to which death should be corged statistically. CUMBERLAND, MD. Address 22. VIOLENCE: If death was due to external causes, fill in the following: BURIAL Date fhereof. Apr. 3, 1947. (Burial, cremation, or removal, Which?) Accident, suicide, or homicide..... GREENMOUNT CEMETERY Where did Injury occur? WRITE (County) (State) (City or town) CUMBERLAND. injured at home, farm, industry, public place (where?) Injured at work? Msans of injury 18. Funeral director EASE 23. SIGNATURE.



PLEASE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

DTICICATE OF DEATH

(12325)
Rog. Dist. No.

CERTIFICAT	E OF DEATH Reg. Dist. No.
1. PLACE OF DEATH: Ollegary	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
City or town	State County Darrett
How long in above place of death?	City or town (If butside city or town limits, write RURAL and give nearest town)
pospital, institution, or street address where death occurred:	Street No
How long in hospital or institution?	2.(a) If veteran, name war.
3. (a) FULL NAME Patrick Dislow	3. (b) Social Security Number
4. Sex 5. Color of race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
male white	20. DATE OF DEATH MAY 19 19 45 22 00 M
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.47. to 70.01/919.47
T. Birth date of deceased (mo., day, yr.) Samuery 29 1947	and that I last saw h and alive on May 19 1947
8. AGE: Years Months Days the less than one day	Immediair cause of death
	manuta But
9. Birthplace Thost Care (Town Legality, and start)	Due to
1D. Usual occupation.	Due to
11. Industry or business	
12. Name	Dther conditions
# 14. Maiden name Betty 2. M. Kange	(Include pregnancy within 3 months of death)
14. Maiden name	Major findings of operations.
16, Informant Clas W. Dishory	Antopsy results
Address arilton, ml.	PHYSICIAN: Please underline the cause to which death should he charged statistically.
17. Outland 20, 1947 (Burial, cremation, or remayal, Which?) Date thereof Market 20, 1947	Accident, suicide, or homicide
Cemetery or crematory.	Where did injury occur? (City or town) (County) (State)
Location andtur md.	Injured at home, farm, Industry, public place (where?)
18. Funeral director G. R. Neinst	Meens of Injury Injured at work?
Address Prostoury Md.	wom a tane to m
19. 3-20 1942 Mus Rauce N. Free Registrar	23. SIGNATURE M.D. or other 3-20-4)
(Date rec d by registrar) Registrar	Address Vale signed

PECT: 1947

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PLAINLY, WITH UNF. is especially important.

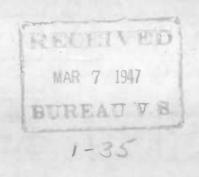
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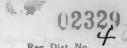
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

3. (a) FULL NAME William Patrick Dishong 4. Sex 5. Color or race 6. (a) Singls, married, widowed, or divorced MEDICAL CERTIFICATION Medical Certification 5. (b) Name of husband or wite 5. (c) If allve, give age	CERTIFICATE OF	DEATH	Reg. Dist. No.
4. Sex 5. Color or race 6.(a) Singls, married, widowed, or divorced MEDICAL CERTIFICATION 2D. DATE OF DEATH March 2 19.4.7., at 2 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 18.4.7., to March 2 7. Birth date of deceased (mo., day, yr.) January 29 1947 Immediate Saure of death 0 Immediate Saure of death 0 10. Date of Death March 2 11. I CERTIFY that death occurred on the date above stated; that I attended disceased from 18.4.7., to 19.4.7. 11. Immediate Saure of death 0 12. I Date of Death March 2 13. Date of Death March 2 14. Sex 19.4.7., at 2 15. Color or race 6.(a) Singls, married, widowed, or divorced MEDICAL CERTIFICATION 20. DATE OF DEATH March 2 19.4.7., at 2 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 19.4.7., at 2 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 22. I Date of Death March 2 19.4.7., at 2 24. Date of Death March 2 19.4.7., at 2 25. Date of Death March 2 19.4.7., at 2 26. Date of Death March 2 19.4.7., at 2 27. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 28. Date of Death March 2 29. Date of Death March 2 20. Date of Death March 2 20. Date of Death March 2 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 21. I CERTIFY that death occurred on the date above stated; that I attended disceased from 19.4.7. 22. Date of Death March 2 23. Date of Death March 2 24. Date of Death March 2 25	town	County (If outside city or town limits, wr (If rural, give LOC eran, name war	ite RURAL and give nearest town)
7. Birth date of deceased (mo., day, yr.) January 29 1947 Immediaio groups of death 000	ale White Diugles 20. DATE O	DEATH March 2	1947 at 200P
S. Birthpisse Treatburg Allegary Md Oue to. 10. Usual occupation. 11. Industry or business	in date of Science Sci	FY that death occurred on the date above st 18.4 ast saw the alive on The action of death Croppe of death	aled: that I attended disceased from 7., to 19.47 UNATION UNATION 4.444
12. Name Ras Unitow Manager Other conditions 13. Birthplace Civilton Manager (Include pregnancy within 3 months of death) 14. Malden name Setty Manager findings of operations. 15. Birthplace Divilton Manager (Include pregnancy within 3 months of death) Major findings of operations. Date of op.	3. 8irthplace 4. Malden name Setty Mr. Deurie 5. Birthplace Major find Major find Major find Autopay r	(Include pregnancy within 3 mont	Date ot op
Address Online Address PHYSICIAN: Please anderline the cause to which death should be charged statisticall 22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide	Date thereof. Mark. 5. 1947 Accident, sometery or crematory. Accident sometery or crematory. A	NCE: tf death was due to external causes, vicide, or homicide	fill in the following; Bate ot



2411 N. Charles St., Baltimore Miss



PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

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VS

DR GROVE CERTIFICAT	E OF DEATH Reg. Dist. No.
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Slate MA RYLAND
3. (a) FULL NAME	3. (b) Social Security Number
### Sex S. Color or race S.	MEDICAL CERTIFICATION 20. DATE OF DEATH. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.47 to Mean 15, 19.47
7. Birth date of deceased (mo., dsy, yr.) MAY 5 1903 8. AGE: Years Months Days If less than one day 43 2/0 6	and that f last saw h allve on 18. Immedia: cause of death OURATION Mayerra Gay
9. Birthplace	Oue to
14. Malden name RACHEL DUCKWORTH 15. Birthplace MARYLAND 16. Informant	(Include pregnancy within 3 months of death) Major fiedings of operations
17. (Burial, cremation, or femoval typich?) Cemetery or crematory. Location	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
18. Funeral director Collemant Good. Address Westernpart Med. 19. March 17,18 47 J. Franklin, M. D. (Date rec'd by registrar). 18. 47 Registrar	23. SIGNATURE Address Medical Edda Date signed 3-15-47.

MAR 25 1947

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

02327
Reg. Dist. No. 4

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infante give residence of mother)		
County Allegany	State Md. County Allegany		
Clly or town			
How long in above place of death?	City or town R. R. R. L. R. L. Intstone Md. (If outside city or town limits, write RURAL and give nearest town)		
Hospital, Institution, or street address where death occurred: Allegany Hospital	Street No. (1f rural, give LOCATION)		
How long In hospital or Institution?. about 2 hours	2.(a) If veteran, name war		
3. (a) FULL NAME	3. (b) Social Security Number		
	220-10-7369		
Delmer Simon Dolly 4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
male white married	20. DATE OF DEATH. March 2 19 47 21 7 55P		
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I affended deceased from		
	and that I last saw h. i.m. all \$\mathrm{18}{\text{0}} \text{Agrch} \tag{2} \text{18} \text{.18}		
7. Birth date of deceased (ma., day, yr.) November 11, 1903	Immediate case of death		
8. AGE: Years Months Days If less than one day	Pulmonary hemorrhage about		
43 3 21min.	3 hours		
9. Birthplace Spruce Mountain, Pendleton, West Virginia (Town, county, and state)	Due to Crushed chest, from auto		
	accident.		
10. Usual occupation. Mechanic	Due to		
fl. Industry or business Allegony Co. Commissioners			
12. Name Altred James Dolly 13. Birthplace Spruce Mountain w. Us.	Other conditions Depressed fracture, right		
13. Birthplace Spruce Mountain, W. Ud.	temporal region. (Include pregnancy within 3 months of death)		
14. Maiden name Elizabeth Mallow			
15. Birthplace Spruce Mountain, West Va.	Major fiodiogs of operations		
16. Informant Mys Carl E. Dolly	Autonsy resolts.		
11 1	PHYSICIAN: Please underline the cause to which death should he charged statistically.		
Address 46 Bedford St. Cum berland, Maryland.	22. VIOLENCE: If death was due fo external causes, fill in the following;		
17 Burial Burial (Burial cremation, or removal, Which?) Date thereof Mdrch 5, 1947 (month) (day) (year)	Accident, suicide, or homicide. Accident. Date of 3-2-1947.		
Cemetery or crematory Dolly Cometery	Route 40-0Mi.east of Cumberland Md. Where did Injury occur? (City or town) Attagrany (SMd.		
Location Near Flintstone, Maryland	Injured at home, farm, Industry, public place (where?) .asabo.ve		
	Blue Ridge Buse hitspired allowers yes		
18. Funeral director. Ohn dalar	Deputy Medical Examiner - Allegany O		
Address Cumberland Wary Land	23. SIGNATURE. H. V. Deming. M. D. H.V. Deming M.D. of our		
March 5 10 47 & P. Franklin U.D.			
(Date rec'd by registrar)	Address Cambuland Md Date signed 3.3-47		

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDANG

PLEASE



information carefully of death clearly and

1. PLACE OF DEATH:

ADING INK. Supply Physicians: please wr

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1314)

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CERTIFICATE OF DEATH

	2. USUAL RESIDENCE (HOME) OF DECEASED:
	(For newborn infants give residence of mother)
	State Oregand County County
l	City or town (ir outside city or town limits, write RUBAL and kive nearest fown)
١	(If outside city or town limits, write RUHAL and give nearest town)
I	Street No. 23 Washington Ot.
ı	(If rural give LOCATION)

How long in above place of death?... Hospital, institution, or street address where death occurred: How long in hospital or institution?.... 2.(a) if veteran, name war...... 3. (a) FULL NAME 3. (b) Social Security Number MEDICAL CERTIFICATION 7. Birth date of deceased (mo., day, yr.) 8. AGE: 10. Usual occupation 11. Industry or business 12. Name 13. Birthplace 14. Maiden na 15. Birthplace Major findings of operations..... PHYSICIAN: Please underline the cause to which death should he charged statistically 22. VIOLENCE: If death was due to external causes, till in the following: Where did Injury occur? Injured at home, farm, Industry, public place (where?) Meens of injury

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from (Include pregnancy within 3 months of death)

MAR 24 1947
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MARYLAND	STATE	DEPARTMENT	OF	HEALT

2411 N. Charles St., Baltimore 83.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County	State Do County fallegany
City or town	City or town
How long in above place of death?	(If outside city or town limits, write RURAL and give nearest town)
Hospital Institution, or street address where death occurred:	Street No. 24 Wales
mules Nuspetal	(If rural, give LOCATION) 2.(a) It veteran, name war
How long In hospital or Institution?	
3. (a) FULL NAME Daniel Studson.	Dues & 3. (b) Social Security Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
m www.	20. DATE DE DEATH MANY 19.47 at 636 PM
8.(b) Name of husband or wife 24 angest Sunt	21. LCSRTIFY that death-occurred on the date above stated; that I attended deceased from
	TRY-18 c 1947, to 20 av (194/
7. Birth date of San	and that I last saw handlive on Man 19.41
deceased (mo., day, yr.) RACE. Years Months Days If less than one day	Immediais cause of death
o. Aut.	Cerebral Remourtage 12 Way
8 3 11 29hrsmin.	Elf Henripalgray
9. Birthplace (Town, county, and state)	Due to.
	A
10. Usual occupation.	Due to
11. Industry or business	
12. Name M. subsection and .	Dther conditions
≥ 13. Birthplace	(Include pregnancy within 3 months of death)
14. Maiden name.	Major findings of operations
15. Birthplace md.	Date of op
16. Informant Grant Russ	Autopsy results
Address Firstburg Md	PHYSICIAN: Please underline the cause to which death should be charged statistically.
R : 1 man 4-1447	22. VIOLENCE: It death was due to external causes, till in the tollowing;
(Burial, cremation, or removal. Which?) Date thereot (month) (day) (year)	Accident, suicide, or homicide
Cemetery or cromotory	Where did injury occur?
Location	Injured at home, farm, Industry, public place (where?)
a Charle A	Means of Injury tnjured at work?
18. Funeral director	1000C/2 0 Sm 0
Address Jacoburg, M.	23. SIGNATURE WOOTH - Lone To M
19.3-4 1947 Mus Newey X. Vog	Tother md M. D. or other 33-4-7
(Date rec'd by registrar) Registrar	Address Date signed



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MARYLAND STATE DEPARTMENT OF HEALTI

2411 N. Charles St., Baltimore 157-9

H	m.E.	B. Ourens) .
11	46	02332	

M. D. or other Date signed...3.

		CERTIFICA	TE OF DEATH	Reg. Dist. No.
Hospital, institution Alle	Cumberland (If outside city or town) place of death?	mits, write RURAL and give nearest town) WKS • death occurred:		mother) oly Allegany orland, Md write BURAL and give nearest town) LOCATION)
3. (a) FULL N.	AME			3. (b) Social Security Number
R	ichard Van I	Everett		MANE
4. Sex	5. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL CE	ERTIFICATION
Male	White	Single	20 DATE DE DEATH March 1.	19.47 at4:10 P
7. Birth date of deceased (mo., c	Years Months Cumberland, (Town,		and that last saw h. Lat. alive on	
12. NameW		. Everett	Dther conditions	
14. Matden n W 15. Birthplace			(Include pregnancy within 8 r	
I I U. INTUINANT	***************************************	berland, Md.	PHYSICIAN: Please underline the cause to wh	hich death should he charged statistically.
17. Bur (Burial, crems	Pow Pow Wes	ill Ceme.	22. VIOLENCE: If death was due to external cau Accident, suicide, or homicide	(County) (State)
tR Fungral divani	Louis Ste	in, Inc.	Msens of injury	Injured at work?
	Cumberland,		MES Ow	in M. J.
	1	017	23. SIGNATURE	

MARGIN RESERVED FOR BINDING PLEASE, WRITE PLAINLY, WITH UNF is especially important.

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CERTIFICATE OF DEATH

Within corporate limits	MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles St., Baltimore (159)	04000
Displace of Death;	CERTIFICATE OF DEATH Rog. Diat	. No. 4
City or town (If outside city or town limits, write How long in above place of death? Hospital, Institution, or street address where death occur	City or town (If outside city or fown limits, write RURAL ar	gary Id give nearest (wn)
	BOY FARREIL non	Security Number
DING Causes of in	MEDICAL CERTIFICATION	19.47 at 1 45 M
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I at the state of the state of death occurred on the date above stated; that I at the state of death occurred on the date above stated; that I at	ended deceased from 19 47 19 47 DURATION DURATION
16. Informant John J. Fam. Address 306 fammberland	Autopsy results. PHYSICIAN: Please underline the cause to which death should be compared to the compared to t	wing: of

RECEIVED MAR 25 1947 BEREAUVE 2-35

2411 N. Chartea St., Battimore 93-d)

CERTIFICATE OF DEATH

	Neg. Dist. 110.		
1. PLACE OF DEATH: allegang	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give seidence of mother)		
7	State County of allegany		
City or town (If outside city or town lights, write RUA), and give nearest town)			
How long in above place of death?	(if outside city or town limits, write RURAL and give nearest town)		
nuers Naspetal	(If rural, give LOCATION)		
How long in hospital or institution?	2.(a) If veteran, name war		
3. (a) FULL NAME	3. (b) Social Security Number		
Charles Wm L	ingel none		
4. Sex 5. Color or race 6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
m w morned	20. DATE OF DEATH. Mar 2 3 147, 216		
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from		
6.(c) It alive, give age years	Mar 10 18 10 May 23 184/		
7. Birth date of deceased (mo., day, yr.) Lake 2-1872	and that I last saw hallve on 19 19 19		
8. AGE: Years Months Days If less than one day	Immediair cause bi death DURATION		
75 2 21hrsmin.	monly		
9. Birthplace Final- Lantt- md.	Due to.		
(Town, county, and state)	900 10-		
10. Usual occupation.	Due 10		
11. Industry or business Clay - munico	SALLAND		
12. Name Assay June	Dither conditions		
13. Birthplace Hermany	(Include pregnancy within 3 months of death)		
14. Maiden name Sanah Mc/ Length	Major findings of operations.		
14. Maiden name Pa	Date of op.		
16. Informant Patent Turnel	Autopsy results		
Address Frotburg, md	PHYSICIAN: Please underline the cause to which death should be charged statistically.		
17 Burial Date thereof Mary 25-194:	22. VIOLENCE: If death was due to external causes, fill in the following;		
(Burial, cremation, br removal. Which?) (month) (day) (year)	Accident, suicide, or homicide		
Cemetery or econology	Where did Injury Occur?		
Location	Injured at home, farm, Industry, public place (where?)		
18. Funeral director.	Means of Injury Injured at work?		
Address Scroolburg Mc	(1) om tane to me		
3-24 4) New House ANKAR	23. SIGNATURE M. D. or other		
(Date rec'd by registrar)	Address Date signed Man 474 +)		

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2411 N. Charles St., Baltimore 946

CERTIFICA	IE OF DEATH	Reg. Diat. No.		
1. PLACE OF DEATH: Allegany	2. USUAL RESIDENCE (HOME) 0 (For newborn infants give residence of	F DECEASED:		
County OF Postered Ct Cumberland Md	State Md. County Allegany			
City or town 951 Bedford St. Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death?	(If outside city or town limit			
Hospital, Institution, or street address where death occurred:	Street No. 951 Bedford S.	<u>t </u>		
951 Bedford St.	(If rurai, give 2.(a) If veteran, name warls.tW.or.	LOCATION)		
How long in hospital or institution?	2.(a) If veteran, name warLS.LW.O.F.			
3. (a) FULL NAME		3. (b) Social Security Number		
John Thomas Flynn		236-05-4245		
4. Sex 5. Color or race 6.(a)Single, married, widowed, or divorced	MEDICAL C	ERTIFICATION		
male white married	20. DATE OF DEATH March 14	19 47 at 12.4		
6.(b) Name of husband or wife Drine Lissure	21. I CERTIFY that death occurred on the date ab			
	10	, to19		
7. Birth date of	and that I last saw h Im aliDead	March 14.		
deceased (mo., day, yr.) May 4 1894	Immediate cause of death	DURATION		
8. AGE: Tears Months Days If less than one day	Angina Pectoris	about		
52 10 10hrsmin.				
9. Birthplace West Virginia				
(lown, county, and state)				
10. Usual occupation Supt. of Construction	Due to			
11. tndustry or business Vandegrift Construction Co.				
Thomas Flynn				
Thomas Flynn 12. Name				
	(Include pregnancy within 3	months of death)		
E 14. Maiden name	Major findings of operations			
15. Birthplace		Date of op		
16. Informant Irene L. Flynn	Autopsy results			
951 Bedford St., Cumberland, Md.	PHYSICIAN: Please underline the cause to w	hich death should be charged statistically.		
Address 17 MAP 10/7	22. VIOLENCE: If death was due to external ca			
17. Date thereof (month) (day) (year)	Accident, suicide, or homicide	Date of		
Cemetery or crematory Trinity Lutheran Cemetery	Where did injury occur?(City or town)	(County) (Chata)		
Cumberland, Md.				
Location	Non-			
18. Funeral director Louis Stein, Inc.	Means of Injury Oput Medical Exa	Injured at work?		
Cumberland. Md.		miner - Allegany C		
Address Of 10: 3. 7	23. SIGNATURE H. V. Deming	I.D. H. V. Duning M		
19 Murch 16, 47 X. T. Tranklin, M.L	C	med Date signed 3 . 1 4 /		
(Date rec'd by registrar) / Registrar	r Addres	Date signed.		

MARGIN RESERVED FOR BINDING

MAR 19 1947

ADING INK. Supply every item of information carefully. The or Physicians: please write the causes of death clearly and legibly.

PLAINLY, vis especially

PLEASE WRITE

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

EALTH

ERTIFICATE OF DEATH

02336 eg. Dist. No. 40

CERTIFICA	Reg. Dist. No	
City or town	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Stale	L
Hospital Institution, or street address where death occurred. How tong in hospital or institution?	Street No. 76 Rever William And (If rural, give LOCATION) 2.(a) if veteran, name war.	<u></u>
3. (a) FULL NAME Joseph Smichael	Frale 3. (b) Social Securi	ity Number
hale nite Single.	MEDICAL CERTIFICATION 20. DATE OF DEATH 10 4	
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated: that I attended d 12.41 19.47 to 20.42 and that I last saw h 1.77 alive on 6.42	
8. AGE: Years Months Days 11 less than one day — 2 9hrsmir	in. Lober Freum onic	DURATION 3 day 5
9. Birthplace	Bue to.	,
11. Industry or business 12. Name harles Bryer 13. Birthplace	Due to	
13. Birthplace 14. Maiden name legaleth In alampho 15. Birthplace 15. Birthplace	(Include pregnancy within 3 months of death) Major fiedings of operations.	
16. Informant Charles Fryer	Aotopsy results	
Address 17. Date thereof	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide	
Location of a puttle Street	Where did injury occur?	(State)
Address Cumberland MA	23 SIGNATURE Cirthus 7. Jones In	D. or other
19. Much 17 1947 S. T. Wauschu, M. Registry		ned 3-17-47

RECEIVED MAR 25 1947

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Status Jones

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CERTIFICATE OF DEATH

/	
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Clipsquing	State MA: County allegances
City or town	21 -4 -
How long in above place of death?	(If outside city or town limits, write RURAL and give nearest town)
Hospital, Institution or street address where death occurred:	Street No. 38 Centernial
- ANLAS	(If rural, give LOCATION)
How long In hospital or Institution?	2.(a) It veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Mary & byolett St.	lass none
4. Sex 5. Color or race 6.(a) Single, madred, widowed, or divorced	MEDICAL CERTIFICATION
7 Tell infant	20. DATE DE DEATH March 9 19 47 219:15:17
	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(b) Name of husband or wife	-ef 27 19 17, 10 May 9 1947
7. Birth date of 2	and that t last saw h A allve on May 9 194-7
deceased (mo., day, yr.)	Immediate cause of death DURATION
8. AGE: Years Months Days It less than ooe day	will departe 4Days
hrsmin.	
9. Birthpiace Town, county, and state)	Due to
(Town, county, and state)	Meases 100g
10. Usual occupation	Due to
11. Industry or business	
12. Name Janes Jlass	Other conditions
13. Birthplace ma	(Include pregnancy within 3 months of death)
14. Maiden name Danis Tunnel	
14. Maiden name	Major fiadings of operations.
The second of th	Date of op.
16. Intermant	Antopsy results
Address	22. VIOLENCE: If death was due to external causes, till in the tollowing;
17 Busial Date thereof Mar 11-1947	Accident, suicide, or homicide
(Burial, cremation, or removal, Which?)	
Cemetery or creatily	Where did injury occur? (City or town) (County) (State)
Location 7	Injured at home, farm, Industry, public place (where?)
18. Funeral director	Meens of injury Injured at work?
Address 173 thing ma	whom cane he mo
0. 103	23. SIGNATURE
19. S- (Date rec'd by registrar) Mus. Massey X. Registrar	Address & Systoling M. Bate signed 3-10-4

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MARYLAND STATE DEPARTMENT OF HEALTH 121)

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			4
Reg.	Diat.	No.	

Elty or Lown. G. C.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
Now long in hospital or institution? 10 DAVS 3. (a) FULL NAME 3. (b) Social Security Number 15. Set Scient of riche 16. (c) Name of husband or wife Scient of riches and that I list supply that death occurred on the date above stated; that I attended preceased from the state of the supply of the supp	How long in above place of death?	StateMARYI, AND
3. (a) FULL NAME MRS 4. Sea MEDICAL CERTIFICATION MRRIDE MRRIP 2. DATE OF EXCHANGE MARRIED MRRIP MRRIP 2. DATE OF EXCHANGE MARRIED 2. DATE OF DEATH AND		
Section of rates and the control of	3. (a) FULL NAME	
18. AGE Years Months S. AGE Years Months Days II less than one day The summedia: creared death of the summedia: creared d	4. Sex 5. Color or race 78.(a) Single, matried, widowed, or divorced	MEDICAL CERTIFICATION 20. DATE OF DEATHMARCH
12. Name	7. Birth date of deceased (mo., dsy, yr.) 8. AGE: Years Months Days II less than one day 72	21. I CERTIFY that dealh occurred on the date above stated; that I attended deceased from 19.47. and that I last sawh 18. allye on Immediate cause of death 19.47. Due to 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.
Autopsy results. Address MCHENRY, MARYLAND 17	12. Name transley Sules 13. 8 rthplace Manager Local County, Penna 14. Malden name succinda Speicht	(Include pregnancy within 3 months of death) Major findings of operations.
Location Alex Accident, Md. Injured at home, farm, Industry, public place (where?) 18. Funeral director Empoy Bolden Address Oakland Mand	Address MCHENRY, MARYLAND 17. BIRIAL (Burial, cremation, or removed. Which?) Birth (day) (year)	PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, iill in the following: Accident, suicide, or homicide
19 March 11, 1947 J. F. Franklin, M. D. S. Stone C. J. J. M. D. or other	Location Meas accident, Md. 18. Funeral director Emroy Boldin Address Oakland md	Injured at home, farm, Industry, public place (where?) Mesans of injury Injured at work?

PLEASE



23. SIGNATURE:

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MAR 19 1947
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To the second of the second of

6.(c) If alive, give age

28

If less than one day

How long in above place of death? 15 412 Hospital, instilution, or street address where death ogcurred:

(aug

Months

1. PLACE OF DEATH:

How long in hospital or institution?..

6.(b) Name of husband or wife.....

3. (a) FULL NAME

7. Birth date of

8. AGE:

deceased (mo., day, yr.)

11. Industry or business 12. Name 13. Birthplace

CERTIFICATE OF DEATH

	Reg	Dist.	No
-			

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) (If rurn), give LOC 2.(a) If veteran, name war..... 3. (b) Social Security Number MEDICAL CERTIFICATION 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (Include pregnancy within 3 months of death) Major findings of operations. PHYSICIAN: Please underline the cause to which death should he charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Whern did Injury occur?(City or town) (State) Injured at home, farm, Industry, public place (where?) Injured at work? Means of injury

information care of death clearly

PLEASE

1B. Funeral director

2. 45. 50. 50. 50. TO THE STATE OF TH E LED LEVEL TO B missellighethe griffethe more Someth well singles APR 1 1947 Littern BUREAU to m . 2.2 - 2 enner. The grant of the grant o sesting the sale and Power Spensylps

Date signed / There. 47.

(Burial, eremation, or removal.

1B. Funeral director.

19 (Date rec'd by registrar)

Address

MARGIN RESERVED FOR BINDING

Water conjunct Built

CE	ERTIFICATE OF DEATH	
1. PLACE OF DEATH: County. Allegany. City or town. Cumberland. (If outside city or town limits, write RURAL and giv How long In above place of death?. Memorial Hospital How long In hospital or Institution? 2. Hours 35. Mir 3. (a) FULL NAME	State W.S.t. Virgor nown Gorman (If outside city or lown No	
Roger Ties Harvey 4. Sex 5. Color or race F.(a) Single, married, widow	red, or divorced	
Male White Single	20. DATE OF DEATH. Marc	
6.(b) Name of husband or wife	ge years and that I last saw h 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
7 - 25hr		
9. Birthplace Mary Land (Town, county, and state)	Due to	
10. Usual occupation Infant Due to.		
11. Industry or business 12. NameWarrenHarvey	Diher conditions.	
14. Malden name Ruby Shreve	Major fiedings of operations	
16. Informant Memorial Hospital	Autopsy results.	
Address Cumberland, Maryland 11 Burnal Date thereo Mary	22. VIOLENCE: If death was	
17 / Zural Date thereof Warg	44,1947	

	Reg. Dist. No	£
. USUAL RESIDENCE (HOME) (For newborn infants give residence of	OF DECEASED: of mother)	
West Virginia	countyGarrett	
ity or lown Gormania (If outside city or town lim	nits, write RURAL and give nearest to	own)
treet No. (If rural, gi	ve LOCATION)	
.(a) if veteran, name war	X	***********
	3.(b) Social Security Numb	er
MEDICAL	CERTIFICATION	- 32
Manala 3	AP7	7 . 7 .
D. DATE OF DEATH March 1,		
1. I CERTIFY that death occurred on the date	above slated; that I attended deceased fr	om, The
1.00 P.M. 1 new.		
nd that I last saw h. I.M. alive on		
mmediais cause of death Comple	my bolon	DURATION
Pramisi		
1.	****	
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ue to	***************************************	
		•••••
ther conditions		
Careline E	lone.	
(Include pregnancy within	3 months of death)	
lajor fiedings of operations		
	gate of op	Lacens
piopsy results to reflect L	ober Permenonia	
HYSICIAN: Please unferline the cause to	which death should be charged statisti	ically.
2. VIOLENCE: If death was due to external		
VIOLENCE: If death was due to external cident, suicide, or homicide	Date of	
2. VIOLENCE: If death was due to external cident, suicide, or homicide	Date of	
VIOLENCE: If death was due to external cident, suicide, or homicide	Date of	

Registrar Address Reserved Ac

BORKAG VS

M. D. or other

Date signed.....

	Reg. Dist. No	
. USUAL RESIDENCE (HOME	E) OF DECEASED:	
tate Teld	County COO O Co	
ity or town(If outside city or town	limits, write ROBAL and give near	est town
treet No. 17 Furni,	give LOCATION)	
.(a) It veteran, name war	•••••	
11 00	3. (b) Social Security A	lumber
Hershberge	11 071 200	
	CED TIEND	
MEDICAL	CERTIFICATION	
D. DATE DE DEATH Was	ch 8 1947	
1. I CERTIFY that death occurred on the da		
3-7-	19. 7 7 10 3 T	19
nd that I last saw halive on		18
10		DURATION
mmediaic cause of death	12-1-0	DOWNTON
mmediai- cause of death	3 Muchon	100
		Marc
ue 10		
ue to		************************
	••••••••••••••••••	
ther conditions	•••••	4
/		
(Include pregnancy with	nin 3 months of death)	
Tajor fiediags of operations		
	Date of op	
<i>,</i>	batc of op.	
Autopsy results	to which death should be charged a	tatistically.
2. VIOLENCE: If death was due to extern	nal causes, fill in the following:	
ccident, sulcide, or homicide	Date of	
Whars did injury occur?(City or to	wn) (County)	(State)
njured at home, farm, Industry, public pla		
Means of Injury	Injured at work?	
/	Mai - M	11)

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2411	N. Charles St., Baltimore 1700
CERTIF	FICATE OF DEATH Reg. Dist. No. 4
1. PLACE OF DEATH: County	(If outside city or town limits, write RURAL and give nearest town)
3. (a) FULL NAME	3. (b) Social Security Number
James Richard Hite 4. Sex 5. Color or race 6.(a)Single, married, widowed, or divorce	MEDICAL CERTIFICATION .
male white single	2D. DATE DF DEATH. March 8 19.47
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7. Birth date of deceased (mo., day, yr.) Morch 20, 1943	
8. AGE: Tears Months Days It less than one day 3 // /8hrs.	Intercranial hemorrhage about
9. Birthplace Cumberland, Allegany, Md (Town county, and state) 10. Usual occupation 64/d	Due to a fracture of the skull hours
11. Industry or business	Due 14.
12. Name James Mervin Hite 13. Birthplace Cumberland Md.	
14. Maiden name Phyllis Davis 15. Birthplace Piedmont W.Va.	(Include pregnancy within 3 months of death) Major findings ol operations.
16. Informant Marmon L. Davis	Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.
Address Cumberland, Md 11	22. VIOLENCE: If death was due to external causes, fill in the tollowing: Accident, suicide, or homicide. Accident Date of 3-7-194 Where did injury occur? Paw Morgan W. Va.
Location Cumber land, Md 18. Funeral director foliage Address Canada Manda Had,	Injured at home, farm, Industry, public place (where?) Highway&R.Ry B. Wasna of InjGollision between Injutation & Auto Deputy Medical Examiner -
19. Marah 10, 19 47 J. P. Franklin,	M.D. or other Registrar Addres Carles Man Date signed 3: 4

MAR 19 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

02345

CERTIFICATE OF DEATH

		. 1
Reg.	Diat.	No. 4

CERTIFICA	IE OF DEATH	Reg. Dist. No	<u>-</u>
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF (For new porn infants give residence of m	other)	
City or town. (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?	City or town (1f outside city or town limits, Street No. 3 0 3	write RURAL and give ne	
303 Columbia States	(If rural, give I		0.0000000000000000000000000000000000000
How long in hospital or Institution?	2.(a) It veteran, name war		444444444444444444444444444444444444444
3. (a) FULL NAME		3. (b) Social Security 214-07-	1 = 00
4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced Married	20. DATE OF DEATH. March.		about
8.(b) Name of husband or wife Margaret P. Sullian Holo	21. I CERTIFY that death occurred on the date above	stated; that I attended dece	
T. Birth date of S.(c) It alive, give age years	and that I last saw h. M. Turand		
8. AGE: Years Months Days It less than one day	Immedia; cause of death	0	at one
9. Birthplace Temporary That Tagen, eounty, and state)	Due to Centerna - Seleva	***	Sernel
10. Usual occupation Celaranese Averher Cetarea	Due to.		250 and
11. Industry or business Colomese Corporation	Sther conditions.	•••••	
13. Birthplace Irelandy	(Include pregnancy within 3 me	onths of death)	.,
14. Maiden name Alisa Thirings 15. Birthplace Wirginia	Major findings of operations		
16. Interment Jaseph Auban	Antopsy results	***************************************	statistically.
Address Gunverland, XIII	22. VIOLENCE: It death was due to external cause. Accident, suicide, or homicide		
(Burial, cremation, or removal. Which?) (though) (day) (year) / Cemetery or crematory Stan Stantas CRS Collaboration	Where did injury occur?(City or town)	(County)	(State)
Location Cumbersland & Brid	Injured at home, farm, Industry, public place (who	ere?)	legenw C
18. Funeral director Address A	Deputy medical mas		to Branch and
19/1/11 core 18 47 & Frankhi M.	23. SIGNATURE TY - Walnut		or other
(Date rec'd by registrar) Registrar	Address	Date signed.	J. 25/15

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

.0 9.45-15M

VS A15

PLEASE



A 25 (C) 11

Within corporate limits? MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles St., Baltimore CERTIFICATE OF DEATH Reg. Dist. No. 2. USUAL RESIDENCE (HOME) OF DECEASED; 1. PLACE OF DEATH: legibly, (For newborn infants give residence of mother ion carefully. City or town ... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?... Hospital institution or street address where death occurred (If rural, give LOCATION) information of death clea How long in hospital or institution?. 2.(a) If veleran, name war...... 3. (a) FULL NAME 3. (b) Social Security Number MEDICAL CERTIFICATION BINDING S.(b) Name of husband or wifs..... Supply every i 6.(c) If alive, give age 7. Birth date of deceased (mo., dsy, yr.) It less than one day 8. AGE: ADING INK. Physicians: p (Town, county, and atate) 1D. Usual occupation ... 11. Industry or bustness Other conditions ... important. 13. Birthplace (Include pregnancy within a months of death) 14. Maiden name. Major findings of operations. 15. Birthpiace LAINLY, especially 16. Informant ... PHYSICIAN: Please underline the cause to which death should be obsrged statistically PLAINLY is especial 22. VIOLENCE: If death was due to external causes, fill in the following; Date thereof. Cu month) (day) (year) Accident, suicide, or homicide..... Where did Injury occur? (State) WRITE Cemetery or crematory (City or town) (County) Injured at home, farm, Industry, public place (where?) Injured at work? Masna of injury 18. Funeral director ASE

In Brings

APR 5 1947 BINAL 3

Address.....

DURATION

ARGIN RESERVED FOR BINDING

(Date rec'd by registrar)

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MAR 17 1947

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

		harles St., Baltimore 872	7
1 2 2	CERTIFIC	ATE OF DEATH	
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
	MARY LAND Mits, write RURAL and give nearest town)	State MARYLAND County ALLEGAN City or town 8 ALTAMONT TERRACE (If outside city or town limits, write RURAL and give nearest to	
How long in above place of death?	death occurred:	Street No	
How long in hospital or institution?30	DAYS	2.(a) if veteran, name war	
3. (a) FULL NAME		3. (b) Social Security Numb	ber
MARGIE HOLLE		215-14-6360	0
4. Sex 5. Color or race	5.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
FEMALE WHITE	SINGLE	20. DATE OF DEATH	7.230
		21. I CERTIFY that death occurred on the date above atated; that I attended deceased fr	
6.(b) Name of husband or wife		Feb. 8 19 47 to 20 47	U 18 4
T. Birth date of		years and that I last aaw h. A. alive on Mar 10	19.4
deceased (mo., day, yr.) 3-7-2 1 8. AGE: Years Months	Days I if less than one day	Immediais cause of death	DURATION
26 0	2hrs.	min. Carebral edema of	
		Lake al sining thrombors	• • • • • • • • • • • • • • • • • • • •
8. Birthplace	county, and state)	suppurative 'A	eev.
10. Usual occupationSECRET	ARY	Due to Chronic mastarditis	
	TIN, FORD'S DRUG		Zev.
E	M	Dther conditions	
13. Birthplace W. Va	•	(Include pregnancy within 8 months of death)	
	RICE	Major findings of operations Chronic masterid	lixes
15. Birthplace MARYLANI		normal lat smir Date of op. Feb	
	Hollen	Autore resplie (above)	
	errace, Cumberland	PHYSICIAN: Please underline the cause to which death should be charged statist	lically.
	25 71 70	22. VIOLENCE: If death was one to external causes, till in the following:	
(Burial, cremation, or removal, Which?			
	ill Cem.		
	land, Md.		*******
	s L. George		
	land, Md.	1 xmman	Jack
2 1	0 1100 11	23. SIGNATURE M. D. or oth	ler -
19. March 13 18.47	Jaseph Crowkler	strar Addrage 115 S. Centre St Date signed 3	-11-

MAR 19 1947

2-35

CEDTIFICATE OF DEATH

02348₀

200	2411 N. Charle	a St., Baltimore (7)
rect	CERTIFICAT	E OF DEATH Reg. Diat. No.
on carefully. The corclearly and legibly.	1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State
ation th cl	How long in hospital or institution?	2.(a) If veteran, name war. 3.(b) Social Security Number
information of death cle	marlys Caral Sumber	tain will security number
of	4. Sex 5. Cold or rice 6.(a) Single, married, widowed, or divorced Famale White Single	MEDICAL CERTIFICATION 20. DATE OF DEATH MEDICAL 20 19 47 at 2130
every item ite the cau	6.(6) Name of husband or wife	21_ICERTIFY that death occurred on the date above stated: that I attended deceased from
ly eve	T. Birth date of deceased (mo., day, yr.) Debracare 17, 1945	and that I last saw h. C. t. Salive on 3.20 19.47. Immediate cause of death DURATION
Supply lease wr	8. AGE: Years Months Days If less than one day	acute bronclutis 3 days.
ADING INK. Physicians: pl	9. Birthplace (Town, county and state)	Due to.
DING	1D. Usual occupation	Due to Whoping Carta
- Tar	12. Name Urin / Hunbertson	Other conditions
Utar	14. Maiden name Swetta River	(Include pregnancy within 3 months of death) Major findings of operations.
lane.	2 15. Birthplace Furthery, M.	Date of op.
AINLY, especially	Address 7 Water MA	Antopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.
PLAINL s especia	17. Burial, cremation, or removal, Which?) Date thereo Date 22 1947 (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
WRITE	Cemelery or crematory Extended Ave.	Where did injury occur?
	18. Funeral director 2. R. Alurst	Meens of Injury Injured at work?
PLEASE	Address Frasthers Md.	23. SIGNATURE A.C. Deely M.D.
PL	19. 3-2 (Date rec'd by registrar) 19.47 Mus. Hauley A. Rogistrar	Address Frastling, TM - Date signed 3,21,47

MARGIN RESERVED FOR BINDING

MAR 24 1947
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WRITE

PLEASE

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/0)

CERTIFICATE OF DEATH

	Reg. Ditt. IVO
1. PLACE OF DEATH: Allegany County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother) State Md. County Allegany McCoole (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) NO 2.(a) If veteran, name war.
3.(a) FULL NAME Ernest A. Jackson	3. (b) Social Security Number 236-01-8073-A
4. Sex 5. Color or race 6.(a)Single, married, wildowed, or divorced Married	MEDICAL CERTIFICATION 20, DATE OF DEATH Mar. 3 1947 21 11:001
6.(6) Name of husband or wife. Nullie Heironimus Jackson 6.(c) If alive, give age 4 7. Birth date of deceased (mo., day, yr.) May 15, 1880	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18. C., to Manual T., 19. 4. 7. and that I last saw hand alive on Manual T., 19. 4. 7. DURATION DURATION
8. AGE: Years Months Days tf less than one day 66 9 18 hrsmin.	Immediais causa al death OURATION
9. Birthplace	Oue to
Sinterment Mrs. J.W. Goldsworthey	(Include pregnancy of thin 8 months of death) Major findings of operations Date of op.
Address Keyser, W. Va. 17. Burial (Burlal, cremation, or removal, Which?) Cemetery or Xamility Queens Point	Antopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Location Keyser, W. Va. 18. Funeral director B. W. Markwood Address Keyser, W. Va. 19. Mark 6 1967 Haginbaker M.	(City or town) (County) (State) Injured at home, farm, Industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-01

marker .

02351

		CERTIFIC	E OF DEATH Reg. Dist. No.	
County ALLEGANY City or town CUMBERIAND (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 5 days			Streel No	
	E. JENKI	NS	love	
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
MALE	WHITE	WIDOWER	20. DATE OF DEATH 3. 27 19.47, 21. 8	
B.(b) Name of husband 7. Birth date of deceased (mo., day, y			21. I CERTIFY that death occurred on the date above stated: that I attended occased from 21. I CERTIFY that death occurred on the date above stated: that I attended occased from 19	
8. AGE: Years	Months	Days If less than one day	Cerebral Hemorkans	
9. Birthplace	RETIRED		Due to.	
12. Name E.D.	PENNA VI.	KINS Ainia SON	(Include pregnancy within 3 months of death)	
14. Maiden name. 15. Birthplace	VA.	Tenkins	Major findings of operations Date of op. 1	
Address 777	+, Sarage	, Md	Antopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistics 22. VIOLENCE: If death was due to external causes, fill in the following:	
	AL, or removal. Which?) The thousand the state of the st	Oate thereof Marks 30 194 (month) (day) (year)	Accident, suicide, or homicide	
	John J.	Holes	Injured at home, farm, Industry, public place (where?) Mesns of Injury Injured at work?	
18. Funeral director Address Cell 19. March	29.19.47	I. P. transclin , M.	23. SIGNATURE M. D. OF other	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Battimore

CERTIFICATE OF DEATH 934

eg.	Diat.	No.	40
			/

	Reg. Dist. 110.
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother) State
Mrs. Lillie May Johnson	Money
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Female White Married	20. DATE OF DEATH March 31 19 47 at 4 P. M
8,(b) Name of husband or wite. Wilbur H. Johnson 7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day 68 9 10 hrs. min. 9. Birthplace	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. 10. 19. and that I last saw her about March 3.1 19.47. Immedia: cause of death DURATION Chronic myocarditis several Due to. Due to. Other conditions. (Include pregnancy within 8 months of death) Major findings of operations.
16. Interment Mrs. Wilson Gross	Autopsy results
Address 159 Bedford St. Cumberland, Md. Burial (Burial, cremation, or removal, Which?) Cemetery or crematory Rose Hill Cem.	22. VIOLENCE: It death was due to external causes, till in the toilowing: Accident, suicide, or homicide
Cumberland, Md. 18. Funeral director Charles L. George Address Cumberland, Md. 18. Date ree'd by registrary Ategistrary Ategistrary	Injured at home, farm, industry, public place (where?) Means of injury Deputy Medical Examiner - Allegany 23. SIGNATURE - V. Deming M. D. A. Deming M. D. ar other Address Sundayland M. D. Date signed 3-3-1/47.

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cisespecially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

WRITE

PLEASE

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APR 5 1947

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2411 N. Charles St., Baltimore 107

02353

CEDTIFICATE OF DEATH

CERTIFICAT	Reg. Diat. No	
1. PLACE OF DEATH: Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
Clly or town. 30 Bedford St. Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)	Stata Md. County Allegany	***************************************
(If outside city or town limits, write RURAL and give nearest town)	City or town	
How long in above place of death? 30		
Hospilai, Institution, or streat address where death occurred:	Sireet No. 30 Bedford St.	
3 0 Bellod St	(If rural, give LOCATION)	
How long in hospital or institution?	2.(a) It veteran, name war	
3. (a) FULL NAME	3. (b) Social Security N	lumber
William Harry Kalbaugh	705-10-819	3
4. Sex 5. Color or race 6.(a) Single, marriad, widowad, or divorcad	MEDICAL CERTIFICATION	,
ar ar		E 70
Male white married	20. DATE OF DEATH. March 18 19 4.7.	
6.(b) Name of huaband or wife	21. I CERTIFY that death occurred on the data above stated; that I attended decase	and from
	19, to	
7 Sinh date of	and that I last asw h.imall DeadMarch18	18.4.7
dacasad (mo., day, yr.) \\ 8 A.C. Yaars Months Days It issa than one day	Immediate cause of death	DURATION
o. Adl.	Broncho-Pneumonia	about
73 9 5hrsmln.		one
9. Birihplace Whatemport allagem Md. (Town, county, and state)	Oua to	week
10. Usual occupation Retired Conssina Watchman		
	Due to	
11. Industry or business Western Manyland RR		
12. Name Delm D. Kallvangh 13. 8irthplace Manaland	Other conditions	0.0202222001000000000000000000000000000
13. 8irthplace Mangland	(Include pregnancy within 3 months of death)	
16	Major findings of operations	
18. Informant Kullmigh	Autopsy results	4 - 41 - 11 - 11 -
Address 30 Bedford St Cumbuland Mil	PHYSICIAN: Please underline the cause to which death should be charged a	tatisticany.
0 . 0	22. VIOLENCE: If death was due to external causes, till in the tollowing;	
17. (Burial, cremation, or removal, Which?) Date thereot (month) (day) (year)	Accidant, suicida, or homicide	
Cemetery or crematory Philas Christing	Where did injury occur?(City or town) (County)	(State)
Location Westernsport Mil	injured at home, farm, Industry, public place (whare?)	
9 ' 0+ . \	Maans of injury Injured at work?	
18. Funeral director	Beputy Medical Examiner - Alle	egany O
Address umbenlynd Ma	23. SIGNATUREH. V. Deming M.D. H. D. S.	and me
Marghan 1/2 Chitmakli mil		
(Date rec'd by registrar) (Date rec'd by registrar)	Addrasa Cumbuland Md Date signed	- 19/47

ADING INK. Supply every item of information carefully. The correctage Physicians: please write the causes of death clearly and legibly. ARGIN RESERVED FOR BINDING WITH UNFA

PLAINLY, vis especially

WRITE

PLEASE

MAR 25 1947 BUREAU VA information c of death clea

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Mans of Injury

diam.	A.	
,,,,,	A	

Reg. Dist. No.

3. (b) Social Security Number

W ect as		TE OF DEATH
roo	. PLACE OF DEATH: Allegany	2. USUAL RESIDENCE (For newborn infants
Jy. Th	City or tows. (If outside city or town limits, write RURAL and give nearest town)	State Laryla: City or town (If outside c
arrefu	How long in above place of death?	Street No. 208

2. USUAL	RESIDENCE (HOM	IE) OF DEC	EASED:
State	Maryland	County	Allegany
City or town		rland	RURAL and give nearest town)
Street No	208 Deca		and give nesseet www.y
	(If rur	al, give LOCAT	TION)
2.(a) If vete	ran, name war		

3. (a) FULL NAME			
	Baby	y Girl	Kane
I. Sex	5. Color or race	6.(a)Sing	le, married, widowed, or divorced
Female	White	S	ingle
i.(b) Name of hu aband o	r wite		
		6.(c) If alive, give ageye
f, Birth date of deceased (mo., day, pr.	March	21, 1	947
B. AGE: Yeare	Monthe		it less than one day
, AGE.			
Birlhplace			ny Co, Waryland
g. BirihplaceCum			ny Co, Waryland
g. BirihplaceCum			ny Co, Waryland
g. BirihplaceCum			ny Co, Waryland
BirihpiaseCum			ny Co, Waryland
g. BirihplaceCum			ny Co, Waryland
9. BirihpiseeCum			
B. Birthplace	William Cumber Bet Wheel	n P. K rland, ty Tho ing, W P. Kan	ny Co, Maryland

			None	
MEDIC	AL CER	TIFICA	TION	
20, DATE OF DEATH	rch 2	21	19.47	al 4 P
21. I CERTIFY that death occurred on th	19.4	2, to	21m	7 19.47
Immediate cause of death	l ati	luta	منا	DURATION
Due to Hydrops	7.9	htyk	112-6	
Dther conditions	**************	==***********	***************************************	\$10700010000000000000000000000000000000
(Include pregnancy	within 3 mon	ths of death)		
Major findings of operations		Date	of op	
22. VIOLENCE: It death was due to er				
Accident, sulcide, or homicide				
Where did Injury occur?(City o	or town)	(Cou	nty)	

WRITE PLEASE

Cemetery or crematory

Cumberland, Nd. William H. Kight 1B. Funeral director Cumberland, -d. Address

Injured at work?

APR 1 1947

5. 3.5

MARYLAND STATE DEPARTMENT

2411 N. Charles St., Baltimore (937)

OF	HEALTH	02355

OFFICE	TILO	4 00000	OF	20 YO 4	PATRICK
CERTI	FIC	AIL	OF	DEA	4851

Reg. Dist. No ...

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County alleganing C. D. C.	State Manyland County allogany
(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? 6.7 mg.	(If outside city or town limits, write RURAL and givo nesrest town)
Hospilal, Institution, or street address where death occurred:	Sireel No. 27 Race Street
27 Kace St.	(If rural, give LOCATION)
How long in hospital or Institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
TRANK IVI, MUS	tner 705-09-9872
4, Sex 5. Color of face 6.(w/single, matried, windowed, or directed	MEDICAL CERTIFICATION
Male White Widowed	20. DATE OF DEATH Grand 19 18 47 at 1 A.
6.(6) Name of husband or wife Catherine & Coline	21. I CERTIFY that death occurred on the date above states; that I attended deceased from
7. Birth date of Section 1. Section 2. Secti	and that I last saw hallye on
deceased (mo., dsy, yr.) Ottober 2, 1879 RACE. Years Months Days If less than one day	Immediais cause of death
8. AGE: Years Months Days If less than one day 67 64/ 5 17	Carrie Ling o colonia
9. Birthplace Cumbeland allegan Mangland (Town, county, and state)	Due to
10. Usual occupation Retined Machinist	Due to
11. industry or business B+ORR	<u>f</u>
12. Name anton Kostner	Other conditions.
Z 13. Birthplace Samuel	(Include pregnancy within 3 months of death)
E 14. Maiden name Many Wallergu Gross	(Include pregnancy within 3 months of death) Major findings ol operations
15. Birthplace Gennary	major nadiags of operations
16 Informant Francis Kastner	Autopsy results
270 6. 6. 000 200	PHYSICIAN: Please underline the cause to which death should be charged statistically.
0 . 0 . 10.417	22. VIOLENCE: If death was due to external causes, till in the following:
17 Date thereof	Accident, suicide, or homicide
Cemetery or crematory St Peters + Pandis Clm	Where did injury occur?
Localion Cumbuland, Md	Injured at home, farm, industry, public place (where?)
18. Funeral director 40UIS STEIN, INC.	Maans of Injury Injured all work?
Address Cumberland Ma	23. SIGNATURE John IV. / Kozpun Us D
19. March 20, 19 47 P. Tranklin, M. D. (Date rec'd by registrar)	Address Leve below (light signed 3/20/4)

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MAR 25 1947

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UNFADING INK. Supply every item of information carefully. The correct age tant. Physicians: please write the causes of death clearly and legibly.

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PLAINLY, V is especially i

PLEASE

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-0

CERTIFICATE OF DEATH

Reg. Dist 235640

1. PLACE OF DEATH: County Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
City or town. Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)	state Maryland county Allegany
(If outside city or town limits, write RURAL and give nearest town) How long in above place of death?	City or town
Hospital, Institution, or street address where death occurred:	Street No. 24 N. Lee St. (if rural, give LOCATION)
24 N. Lee St.,	
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b). Social Security Number
Alfred J. Kasubick 4. Sex 5. Color or race 6.(4)Single, married, widowed, or divorced	286-05-5788
4. Sex 5. Color or race 6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION about
male white married	20. DATE DF DEATH March 4 19 47 at 8 A.
6.(b) Name of husband or wife Mildred Beauchamp	21. I CERTIFY that death occurred on the date above stated; that I attended decessed from
5 (a) It allow give and 31	
7. Birth date of deceased (mo., dsy, yr.) Nov. 24, 1911	and that I fast sew h. i.m. aiDead March 4 19.47
	Immediate cause of death
8. AGE: Years Months Days tit less than one day	Cardio-pulmonary hemorrhage At once
Brisbin, Penna.	Due to Shot himself with a 20
(Town, county, and state)	gauge shotgun
10. Usual occupation. Electrician	Due to domestic troubles
11. Industry or business Electrical Repair shop	
單 12. Name Albert Kasubick	Dther conditions
12. Name Penna. Penna.	
	(Include pregnancy within 3 months of death)
14. Maiden name Margaret Kauczka Penna.	Major fiedings of operations
≥ 15. Birthplace	Date of op.
16. Informant Mrs. Mildred Kasubick	Actopsy results
Address 24 N. Lee St., Cumberland, Md.	
Burial Date thereof Mar. 6, 1947 (Burial, cremation, or removal, Which?)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
(Burial, cremation, or removal, Which?) (month) (day) (year)	Accident, suicide, or homicide. Suicide Date of 3-4-47
Cemetery or crematory S. S. Peter & Paul Cem.	Where did in jury occur? Cumberland Allegany Md. (City or town) (County) (State)
Location Cumberland, Md.	Injured at home, farm, Industry, public place (where?)
18. Funeral director Charles L. George	Mapns of injury as above Injured at work? no
Cumbenland Md	Deputy Redical Examiner - Allegany Oc
Address Odinbertalia, Ma.	23. SIGNATUREH. V. Deming II.D. H. V. Demany M. D. or other
19 March 5, 1047 & f. Daullin M.D	
(Date rec'd by registrar) Registrar	Address Cumbuland Ind Date signed 3 44 4

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore CERTIFICATE OF DEATH

1. PLACE OF DEATH: County Allegany	2. USUAL RESIDENCE (HOME) OF DECE (For newborn infants give residence of mother)	ASED:	
City or town. Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)	State Md. County County		
How long in above place of death?	City or town. Cumberland (If outside city or town limits, write F		rest town)
Hospilal, Institution, or street address where death occurred: Allegany Hospital	Street No. 312 Avirett Ave. (If rural, give LOCATI		
How long In hospital or Institution? 2 days 5 1/2 hrs.	2.(a) If veleran, name war	***************************************	
3. (a) FULL NAME	3. (b) Social Security I	Number
Walter J. Keifer	3	14-05-	4966
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIF	ICATION	
male white married	2D. DATE OF DEATH March 29	19.4.7	at 9.P. M
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated:		
	and that I last saw h im all vDead Mar		
7. Birth date of deceased (mo., day, yr.) Aug. 21 -1892	Immediai= cause of death		DURATION
8. AGE: Years Months Days If less than one day	Intercranial hemorrha		2 days
54 7 8min.			5 1/2
9. Birthplace	Due lo a fracture of the	skull	hours
1D. Usual occupation. Engineer	Due to a fall from a ladd	er	400000000000000000000000000000000000000
11. Industry or business Queen City Brewing Co.	while at work, Queen	dity	
¥ 12. Name Wantling Keifer	Dther conditions Brewing Co.		***************************************
Mantling Keifer 12. Name Maryland Ma	(Include pregnancy within 3 months of		
14. Malden name Rose Hammersmith 15. Birthplace Maryland			
15. Birthplace Maryland	Major findings of operations		
Heben Keifer			
10. Intermant	Antopsy results	h should be charged	statistically.,
Address 312 Avirett Ave., Cumberland, Md.	22. VIOLENCE: If death was due to external causes, fill le	in the following:	į
Burial Burial Date thereof April 1, 1947 (Burial, cremation, or removal, Which?) St. Pottonia & Poulla Competency	Accident, suicide, or homicideaccident	Date of 3	27.47
Cemetery or crematory St. Feter's & Faul's Cemetery	Where did Injury occur? Cumberland (City or town)	Allegany (County)	(State)
Location Cumberland, Maryland.	Injured at home, tarm, Industry, public place (where?) 🔾	ueen Cit	y Brewin
18. Funeral director Louis Stein, Inc.	Meens of Injury Fell from ladde Deputy Medical Examiner	twijured at work? Y	es any Co.
Address Cumberland, Md.		WW.	200
19 March 31, 19 47 J. P. Tranklin, M. D	23. SIGNATURE H. V. Deming M.D.	М. D. с	<1/
(Date rec'd by registrar) (Date rec'd by registrar) (Date rec'd by registrar)	Address amfuland Mr	Date signed	3 /30/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ARGIN RESERVED FOR BINDING



VS A15

MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles St., Baltimore 23

Reg. Diat. No.

02358

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CERTIFICATE	OF	DEATH	

1. PLACE OF DEATH: PROGRAMMI	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
City or town	State Masselasta County allgany
City or town	City or town
Hospital, institution, or street address where death occurred.	
	Street No
How long in hospital or firstitution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Emma G. Dumm Sa	uny
4. Sex 5. Color or race 5.(4) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Gien ale Shite, Indowed	20. DATE DF DEATH ON as // 19457 at / 140 P
8.(b) Name of husband or wife John Renny	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
	m h 9 18 47, 10 Deschool 1 19 47
7. Birth date of	and that I last saw h A alive en Malle
deceased (mo., day, yr.) 8. AGE: Years Mooths Days If less than one day	Immediate cause of death Children Jeann Lagra DURATION
8. AGE: Years Mooths Days If less than one day	
I so ma milion a lillian unter	and a second
8. Birthplace Town, country, and stages	/ fue to
10. Usual occupation Amuservos R	
11. Industry or business Own Rome	Due to
= 12 Name Sames Juins	Dither conditions
13. Birthplace Oseland	
14. Malden name Sara.	(Include pregnancy within 3 months of death)
14. Malden name 15. Birthplace Orsland	Major findings of operations
(1) 21 1	Date of op.
16. Informant The Land State Comment	Antopsy results
Address Hagerstown I and	PHYSICIAN: Fleuse underline the cause to which death should be charged statistically.
1. Busing 8701.14 194	22. VIOLENCE: If death was due to external causes, fill in the following;
(Burial, cremation, oy removal. Which?) Date thereof (mouth) (day) (year)	Accident, suicide, or homicide
Cemetery or crematory & t. Junkalla Climetary	Where did injury occur?
Location Frontburg a hid	Injured at home, farm, Industry, public place (where?)
m. 2 /10 h 21.2	Means of injury Injured at work?
18. Funeral director Additional distribution of the state	
Address Lonaconing, and	23. SIGNATURE HASSA Dy-) Hodyson Tyll
19 mary 13 1947 Jamette M Soal	M. D. or other

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Within corporateRuHODGES & MARYLAND STATE DEPARTMENT OF HEALTH DR. COOPER 2411 N. Charles St., Baltimore 159 CERTIFICATE OF DEATH Reg. Dist. No... 2. USUAL RESIDENCE (HOME) OF DECEASED: . PLACE OF DEATHY (For newborn infants give residence of mother) MASSING COUNTY CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town) (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution to street address men defin Accurred: clearl (If rural, give LOCATION) How long in hospital or institution?..... 2.(a) If veteran, name war...... 3. (a) FULL NAME 3. (b) Social Security Number BABY BOY KIFER (PREMATURE) 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced MEDICAL CERTIFICATION BINDING MALE 20. DATE OF DEATH MARCH 30, 1947 . I:00 A.M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6.(b) Name of husband or wife..... 19.7.7 to 30 Um FOR 7. Birth date of MARCH 28, 1947 deceased (mo., day, yr.) 8. AGE: If less than one day RESERVED 10. Usual occupation..... ARGIN 11. Industry or business 12. Name 12. Name (Include pregnancy within 3 months of death) RITTH BORROR 14. Maiden name..... Major findings of operations ... 15. Birthplace PENNA. PHYSICIAN: Please underline the cause to which death should be charged statistically, 22. VIOLENCE: If death was due to external causes, fill in the following: 17. (Burial, cremation, or removal, Which? PL. Accident, suicide, or homicide..... Where did injury occur?(City or town) (County) (State) Injured at home, farm, industry, public place (where?) Injured at work? Msans of Injury Date signed 30 lear 4

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Wife

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1		Reg.	Dist.	No	4	6

CERTIFICAT	TE OF DEATH OF Reg. Dist. No. 45				
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) PENNSYLVANIA County BEDFORD City or town BEDFORD (If outside city or town limits, write RURAL and give nearest town) Street Ho (If rural, give LOCATION)				
3.(a) FULL NAME MR. GEORGE KOONTZ	3. (b) Social Security Number				
4. Sex 5. Color or race 8.(a)Single, married, widowed, or divorced MALE WHITE WIDOWED	MEDICAL CERTIFICATION 20. DATE OF DEATH MARCH 26 19. 47. at 1:22. A				
6.(b) Hame of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. H.T., to 326 - 19. H.T., and that I last saw him alive on 32.5				
9. Birthplace PENNSYLVANIA (Town, county, and state) 10. Usual occupation RETIRED 11. Industry or business 12. Hame WILLIAM KOONTZ	Due to Dither conditions Described by the conditions of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.				
Address 17. Burial (Burial, cremation, or removal, Which?) Cemetery or crematory. Bed for d. Cemetery Location. Bed for d. Par. 18. Funeral director. John J. J. P. Janklin, M. D. (Date ree'd by registrar) Registrar	22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide				

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The sespecially important. Physicians: please write the causes of death clearly and legibly PLEASE WRITE VS A15

MARGIN RESERVED FOR BINDING



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VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02361

Reg. Diat. No.

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
Sounty Allegany Sity or town Chim Berland	State 17.d County 17/1e 9041
(If outside city or town limits, write RURAL and give nearest town) low long in above place of death?	City or town
low long in above place of death?	Street No. 224 Mary land Ave
924 Maryland Ave	(If roral, give LOCATION)
low long tn hospital or institution?	2.(σ) It veteran, name war
Thomas Wimbert Lashl	3. (b) Social Security Number 220-10-8975
Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
M Widowed	20. DATE DE DEATH MAYEL 29 19.47 at 1:15 P.
(b) Name of husband or wife Mary Blanche Inses	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(c) if alive, give age	170-22 28 1847, 10, March 291847
deceased (mo., day, yr.) Moreh 27, 1876	and that I last saw h. A. 12 alive on
B. AGE: Years Months Days It less than one day	Immediate cause of death
7/ 0 2hrs.	nin.
1. Sirinplace Artemos Bedford Co., Po. (Town, coosty, and state)	Due to.
D. Usuat occupation Laborer	
11. Industry or business General Work	Due to
12. Name	Dther conditions Office School
	(Include pregnancy within 8 months of death)
14. Malden name	Major lindings of operations
16. Informant Mesa Haras phose y Innes	Autopsy results
Address 924 Moryland Ave.	22. VIOLENCE: If death was due to external causes, fill in the following;
(Burial, cremation, or removal. Which?) Date thereof April (month) (day) (year)	Accident, suicide, or homicide
Cometery or crematory Mt. Hope Chriatian Cometery	
Location Near Artomas, Pa. 7	injured at home, farm, industry, public place (where?)
18. Funeral director Askey A. Holes	Means of Injury Injured at work?
Address Carle land Red.	a la la
Address Cultural Paris	23. SIGNATURE

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CERTIFICATION TRANSPORT

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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02362

CERTIFICATE OF DEATH

CERTIFICAT	Reg. Diat. No	******
1. PLACE OF DEATH: county near	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
City of two Rural) Amcelle Acres Cresantown	State Md. county Allegant	***************************************
City or town Rural Amcelle Acres Cresaptown I (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 80 m	City or town Rural Near Cresaptowil N (If outside city or town limits, write RURAL and give nea	rest town)
Hospital, institution, or streef address where death occurred: Omcella Acrise	STITE No. AMCELLE ACTES (If rural, give LOCATION)	
How long in hospital or institution?	2.(a) if veteran, name war. More	
3. (a) FULL NAME	3. (b) Social Security	Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
male white married	20, DATE DF DEATH March 26 19 47	about
a - 00 Ma. Ya.	21. I CERTIFY that death occurred on the date above stated; that I attended decea	sed from
6,(6) Name of husband or wife Angellus May desse		
	im Dood March 26	
7. Birth date of	and that I last saw him a Dead March 26	
	Immediate cause of death	DURATION
8. AGE: Years Months Days If less than one day	Coronary occlusion	at
87min.		once
9. 8irthplace Cressptwww. allenn Mungland (Town, county, and state)	Due fo. Arterio sclerosis	several
Car. LE		years
1D. Usual occupation.	Due fo	
f1. Industry or business 0 ww		
12. Name Fralerik J. Lepse 13. Birthplace Maryland	Dther conditions	••••••
	(tnclude pregnancy within 3 months of death)	
# 14. Maiden name	Major findings of operations	
14. Maiden name Ithmit 15. Birthplat Whynny	The state of the s	
0 0	Date of op	
16. Informant & consul desse	Autopsy results	
Address ancelle acres Cresytown, Md.	22. VIOLENCE: If death was due to external causes, fill in the following:	oteriorically.
Burial, cremation, or removal, Which?) Date thereof Mar 3 1 1 4 7 (month) (day) (year)	Accident, suicide, or homicide	********************
Cemetery or crematory. Lance Cerutery	Where did injury occur?	(State)
Location Consentations, Md	injured at home, farm, industry, public place (where?)	
18. Funeral director Line Stein Inc	Meens of Injury Deputy Medical Examiner - Alleg	ony ()
Address Cumbarland Md	1 1	
19. (Date rec'd by registrar) 19. (Registrar)	23. SIGNATURE. H. V. Deming M. D. M. D. M. D. C. M. D. C. Date signed 4.	
(Date rec a plice poster)	. desired and a series of the	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02363

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County	City or town Cumber on d City or town (If outside city or town limits, write RURAL and give nearest town) Street No. ZZI Mary 5+,
How long in hospital or institution? 3 days	(If Peral, give LOCATION) 2.(a) Il veleran, name war.
3. (a) FULL NAME Rebecca Ella Leasure	3. (b) Social Security Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced Divorced	MEDICAL CERTIFICATION 20. DATE OF DEATH 70 4 5, 19 47 21 11:30 8 1
6.(b) Name of husband or wife Ward Leasure 6.(c) If allve, give age 69 years 7. Birth date of deceased (mo., day, yr.) Tonuory 19, 1879	21. LCERTIFY that death occurred on the date above stated: that I attended deceased from 19
8. AGE: Years Months Days It less than one day 48 / 19hrsmin.	Immediais cause of death OURATION Danielos Americani Roger
9. Birthplace Cumberland Mary and (Town, county, and state) 10. Usual occupation House Keeper	Oue 10. Chrenlyed arterorlen year,
11. Industry or business Own home 12. Name	Other conditions
14. Maiden name Millie Robinette 15. Birthplace Allegary Co., Mory land	(Include pregnancy within 3 months of death) Major findings of operations
Address ZZI Mary St. Comberland, Md.	Autopsy results
17. Burial, cremation, or removal. Which?) Oate thereof (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or crematory Mensorial Carlo	Where did Injury occur?
18. Funeral director John J. Ha for Address Calebra Jand Wed.	Meens of injury Injured at work? 23. SIGNATURE B. M. Schudler 200 c.
19. March 10,18 4.7 J. P. Franklin, M.L. Registrar	Address 4 Person Date signed Much 19/9



(Date rec'd by registrar)

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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eg.	Dist.	No.		1

Mar.			CERTIFICAT	TE OF DEATH	40
1. PLACE OF DEATH: County				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland County Allegany Cumberland City or town (If outside city or town limits, write RURAL and give neare Street No. (If rural, give LOCATION) 2.(a) It veteran, name war. 3. (b) Social Security No.	
		MARY C	ASENHAUSE LUECK	none.	
4. Sex Female	5. Color or race White		e, married, widowed, or divorced Married	MEDICAL CERTIFICATION 20. DATE DF DEATH. March 31, 1947	9:45 A.N
6.(b) Name of husband of husband of the husband of deceased (mo., day, yr	Cambani	6.(c) It allve, give ageyears	23. I CERTIFY that death occurred on the date above stated; that I attended decease 19. 4 to Worch 3 and that I last saw has alive on World 3	ed from 19. 7
8. AGE: Years	Months	Days	If less than one day	Immédiair cause of death	DURATION
74	7	22		-drive	3 yrs
tD. Usual occupation	Housewi	Ĉe	ny Co., Md.	Due to.	Ly
12. NameHei	Germany			Diher conditions	**********************
	Anna Mi	ller		(Include pregnancy within 3 months of death)	
t 4. Malden name	Cumberla		med and	Major findings of operations	
	n Lueck	and, wa	ryrand.		
16. Informant			C	PHYSICIAN: Please underline the cause to which death should be charged sta	tistically.
17. Buria.	or removal. Which	Date ther	Cumberland, Md. eof. 2 April 1947 (month) (day) (year)	22. VIOLENCE: It death was due to external causes, till in the following; Accident, suicide, or homicide	
Cemetery or cremator	, St. 1	Peter's	& Paul's Cemeter	Where did Injury occur?	State)
Location Cum	berland, 1	Marylan	d.	Injured at home, tarm, Industry, public place (where?)	
t8. Funeral director	Louis Stand,	ein, In Marvla	ic.	Maena of Injury Injured at work?	24 19
19. (Date/rec'd by reg	19+	0 4	Franklin M. L. Registrar	23. SIGNATURE. M. D. oz. Address. Bate signed.	13/47

WITH UNFADING INK. Supply every item of information carefully. The correct age important. Physicians: please write the causes of death clearly and legibly. FOR BINDING MARGIN RESERVED WITH PLAINLY, vis especially

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MARYLAND	STATE	DEPARTMENT	OF	HEALTH

2411 N. Charles St., Baltimore Bla

02366 Dr Raymond Reeves

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	Dist.		6	0	
Reg	Dist	No.			

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Allegany	state Maryland county Allegany
City or town Rarton (If outside city or town limits, write RURAL and give nearest town)	D 1
How long in above place of death? 80 years	City or town
Hospital, Institution, or street address where death occurred: Latrohe St.	street No. Latrobe St.
•••••	(If rural, give LOCATION)
How long in hospital or Institution?	2.(a) It veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Annie Thomas Mal	
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Female White Married	20. DATE DE DEATH 152 Ch 27 19.47 , at 4:10p
6.(6) Name of husband or wite "illiam Malcolm	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
	3/20/47 19 to 3/27 19
7. Birth date of	and that I last saw h alive on 227
8. AGE: Years Months Days tt less than one day	Immediai suse ol death DURATION
8 / 7 6hrs.	min Clarand Coelles Valledan
0(1)	Me af thebeat
S. Birthplace Parton, Allegany, maryland (Town, county, and state)	Due to
10. Usual occupation House wife	
11. Industry or business Own home	Due to
	Dither conditions
	(Include pregnancy within 3 months of death)
14. Maiden name Mary Buckel 15. Birthplace England	Major findings of operations
2 15. Birthplace England	Date of op.
16. Informant Kenneth Malcolm	Autopsy results
Address Westernport, Maryland	PHYSICIAN: Please underline the cause to which death should be charged statistically.
	22. VIOLENCE: It death was due to external causes, till in the following;
(Burial, cremation, or removal. Which?) (month) (day) (year	Accident, suicide, or homicide
Cemetery or crematory Laurel Hill Cemetery	Where did injury occur?
Location Moscow, Maryland	Injured at home, tarm, industry, public place (where?)
18. Funeral director Ellsworth S. Boal	Means of Injury Injured at work?
Wast 15	The state of the s
Address esternort, Maryland	M. D. or other
(Date red by registrar) Registrary	Strar Address Messenston Jan Date signed 3/29/6/



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No.

· OBITITION	E OI BEATH	Reg. Dist. No.
1. PLACE OF DEATH: County Allegany	2. USUAL RESIDENCE (HOME) OF DEC (For newborn infants give residence of mother	EASED:
City or town. Cumperland Md. (If outside city or town limits, write RURAL and give nearest town)	State Wa Va County County	
How long in above place of death?	City or town. Wiley Ford (If outside city or town limits, write	
Memorial Hospital How long in hospital or institution? about 1.3/4hrs.	(If rural, give LOCA) 2.(a) if veteran, name war	
3. (a) FULL NAME	3.	(b) Social Security Number
Linda Ray Malone		/Ml/
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced female white single	Manch 24	
Temero will be strigto	20. DATE OF DEATH March 24	19 47 at7.55A
6.(ò) Name of husband or wife	21. I CERTIFY that death occurred on the date above state	
7. Birth date of deceased (mo., day, yr.) Tonuory 10, 1947	and that I last saw her Dead Har	ch 19 4
8. AGE: Years Months Days If less than one day	Immediate cross of death	ADOUT
0 2 14hrsmin.	Broncho Pneumonia	days
9. Birthplace Cumber land, Allegany, Maryland (Town, county, and state)	Due to	
10. Usual occupation. Infant	Due fo	
11. Industry or business 12. Name Donold A. Malone 13. Birthplace Cumberland, Md	Diher conditions	
	(Include pregnancy within 3 months	of death)
14. Malden name Margaret Williams 15. Birtholiace Broad to P. Po.	Major fiedings of operations.	
\$ 15. Birthplace Broad top, Pa,		
16. Informant Donald A. Molone	Autopsy resolts	ath should be charged statistically.
Address Wiley Ford, W. Vo.	22. VIOLENCE: If death was due to external causes, fill	
(Burial, cremation, or removal. Which?)	Accident, suicide, or homicide	
cemetery or crematory Ft. Ashby Cemetery	Where did injury occur?(City or town)	(County) (State)
·Location Ft. Ashloy W. Va.	Injured at home, farm, industry, public place (where?)	
18. Funeral director John Marie Mari		Injured at work?
Address Certification of Description of	23. SIGNATURE H.V.Deming M.D.	M. D. or other
(Date rec'd by registrar)	Address Cumbuland n	1 Date signed 3-24/4

MARGIN RESERVED FOR BINDING

WITH UNFADING INK. Supply every item of information carefully. The correct age important. Physicians: please write the causes of death clearly and legibly.

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WRITE

PLEASE



information carefully. The of death clearly and legibly

WITH UNFADING INK. Supply every item of important. Physicians: please write the causes

PLEASE WRITE PLAINLY, is especially

Address

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1060

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County allegasses City or fown Calabaland	State und county aflegany
(If outside eity or town limits, write RURAL and give nearest town)	City or town
How long in above place of death?	Street No. 531 Henderson Blod.
531 Herselson Bera.	(If rural, give LOCATION)
How long in hospital or institution?	2.(a) It veteran, name war
George Joseph &	Nall
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
male white married	20. DATE OF DEATH March 30 18 4.7 21 7:30 PM
6.(b) Name of husband or wife. Barbara Miller Mall	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
S.(c) If alive, give age	22 1947 10 level 30 1947
7. Birth date of deceased (mo., day, yr.) Jan 22 1865	and that I last saw had alive on DURATION
8. AGE: Years Months Days It less than one day	Immediaic cyuse of death Colors
82 2 8hrsmin.	
9. Birlhplace Cumberland allegan, Co, And.	Due to. Colon Structure / Colon
10. Usual occupation Petined	Due to
11. Industry or business Clothing Store Employee	ULE IL.
12. Name John Matt	Other conditions
	(Include pregnancy within 3 months of death)
14. Maiden name	Major findings of operations
7. 00	Date of op
16. Informant Mas James Maries	Autopsy results
Address 320 Holland St-Cumbr. Wa	22. VIOLENCE: if death was due to external causes, fill in the following:
(Burial, cremation, or removal. Which?)	Accident, suicide, or homicide
Cemelery or crematory St. Peter + Couls Countered	Where did injury Occur?
Location Cumberland Md O	Injured at home, farm, industry, public place (where?)
18. Funeral director.	Means of injury injured at work?
	2/ / / / / / / ()

23. SIGNATURE

Registrar Address

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59.2)

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/	108.010.010.000.000	
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (POD newborn infauts give residence of mother)	
County Quality	marriand allegarian	
(If outside city or town finits, write RURAL and give nearest town)	F Dab'	
How long in above place of death? 46 4 4 9 1000, 13 day	City or town	
Hospital, instilution, or streef address where death occurred:	Streel Na.	
	(If rurai, give LOCATION)	
How long in hospital or institution?	2.(a) If veteran, name war.	
3. (a) FULL NAME Michael Francis Mac	3. (b) Social Security Number	
4. Sex 5. Color or race 6.(α) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
Male Ahite Single	20. DATE DF DEATH	
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I affended deceased from	
	March 10 19.47, 10 Red 12 19.47	
7. Birth dalo of 90 years	and that I last saw have allive on bould 1, 1 19.47	
deceased (mo., day, yr.) Ollary a 7 900	Immediate cause of death Chicagon arthur	
8. AGE: Years Months Days If less than one day 46 9 /3	Benedial ashbara	
9. Birthplace Pelano allegany Cen, Md.	Due fo	
10. Usual occupation Retired		
, 6	Due 1a	
11. Industry or business		
12. Name Michael Milabel 13. Birthplace Pekin	Dther conditions	
Z 13. Birthplace (PERM)	(Includs pregnancy within 8 months of death)	
E 14. Maiden name. A Many A antina	Major findings of operations	
15. Birthplace Imaconing, Md	Date of op.	
16. Informant mr. Michael M. Cabe	Autopsy results	
Address Peking Md	PHYSICIAN: Please underline the cause to which death should be charged statistically.	
B 11 1 15 10100	22. VIOLENCE: If death was due to external causes, fill in the following:	
(Burial, cremation, or removal, Which)	Accident, suicide, or homicide	
Cemetery or crematory St. Babriels Commetery	Where did injury occur?	
Baiton M.d.	Injured of home, farm, industry, public place (where?)	
Location On Line Location	Means of Injury Injury Injury	
18. Funeral director	means of injury	
Address I maconing, Mid	Herry Mr. Hodgen M. C.	
march 12 17 (At) B-1	23. SIGNATURE M. D. or other	
(Date rec'd by registrar)	Address Luctoring and Date signed Mela 13 47	

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PLEASE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

og. Dist. No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (Fig. newborn infants give residence of mother)	
County Ullegary	Man la	
(If outside city or town limit, write RULAL and give nearest town)	State J. County	
How long in above place of death?	City or town (If outside city or town limits, write RUNAL and give nearest town)	
Hospital, Institution, or street address where Cath occurred:	Street No.	
How long in hospital or institution? 2 weeks	(If rural, give LOCATION)	
3. (a) FULL NAME	3. (b) Social Security Number	
Deorge amos m'/	euzie 218-10-4307	
4. Sex 5. Color or race 5.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION P.	
Male White Widower	20. DATE DF DEATH March 1947 21/2:40 M	
6.(6) Name of husband or wife. Rosetta mc Reusie	21 I CERTIFY that death occurred on the date above stated; that I attended depeased from 7 19 47	
7. Birth date of	and that I fast saw h. / M. alive on March 7 18 47	
deceased (mo., day, yr.) March 2 1875	Immedia: cause of death	
8. AGE: Years Months Days If tess than one day	Chronic myocarditis -	
hrsmin.		
9. Birthplace	Due 10. Plansing e effection (77) 2 W/CS.	
1B. Usual occupation dantar	Ostoria collegia	
11. Industry or business (Hotel	Due to.	
	Dither conditions.	
12. Name Transis m Tenge 13. Birthplace Daviett Country md		
# 14. Maiden name Laraly Darlits	(Include pregnancy within 3 months of death)	
14. Malden name Sarah Parlita nd	Major findings of operations.	
1 12 - 201 Ap. 17.41 N.	Autopsy results.	
16. Informant	PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Address Day 100 100 100 100 100 100 100 100 100 10	22. VIOLENCE: If death was due to external causes, fill in the following;	
11. Date thereof. (Burlal, cremation, or removal). Which?)	Accident, suicide, or homicide	
Cemetery or crematory At Michaels	Where did Injury occur?	
Location The three Md	Injured at home, farm, Industry, public place (where?)	
18. Funeral director. O. R. Deirst	Means of injury Injured at work?	
Address ETRASTITE MA	2/12 M: 10 m a.	
AUDIESS (1)	23. SIGNATURE M. D. og other	
19. 3 - 2 197 Mus Xauly N- Qui	Address Frostling Md Date signed 3/8/47	

MAR 11 1947
BUREAU V 8

1700

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CERTIFICAT	TE OF DEATH Reg. Dist. No.
1. PLACE OF DEATH: County. City or town. (It outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State
Ria marie m= Kensie	3. (b) Social Security Number
4. Sex 5. Color or race 5.(a) Single, married, widowed, or dispred 7emale White	MEDICAL CERTIFICATION 20. DATE OF DEATH March 18 1947 at 9:00 Q.M
8. (b) Hame of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.4.7. to March 18.4.7. and that I last saw h Pilot alive on March 17. Immediate cause of death present the built bu
10. Usual occupation. 11. Industry or business 12. Name. Elmen Arthur Market 13. Birthplace Charletaure: & braconing ml. 14. Maiden name. Mary Blubaugh 15. Birthplace Yilmer md. 16. Informant Mary Elmer Market 16. Informant Mary Elmer Mary Elmer 16. Informant Mary Elmer Mary Elmer Mary Elmer 16. Informant Mary Elmer Mary Elmer Mary Elmer 16. Informant Mary Elmer Mary E	Due to
Address S. Onco Maryland 17. (Burial, cremation, or removal, Which?) Cemetery or cremato C. (Burial, cremato) C.	PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MAR 24 1947 BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99-0

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CERTIFICAT	E OF DEATH Reg. Dist. No.
1. PLACE OF DEATH: allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
City or town (If queside city or town limits, write HORAL and give nearest town)	State Md County County
How long in above place of death?	City or town
How long In hospital or Institution?	2.(a) It veteran, name war
3. (a) FULL NAME Samuel G. Mc/	(a. (b) Social Security Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced Single	MEDICAL CERTIFICATION 2D. DATE OF DEATH MORCH 5 18 47 at 6 5
6.(b) Name of husband or wife	21 CERTIFY that death occurred on the date above stated; that Lattended deceased from 19. 47., to 19. 44.
T. Birth date of deceased (mo., day, yr.) Mov 3 - 1877	and that I last saw h lalive on Manual 19.
8. AGE: Years Months Days If less than one day 2	Immediair cruse of death from or hage 1/6/4/
9. Birlhplace	Due to Approximent 245
10. Usual occupation	Due to
11. Industry or business 12. Name 13. Birthplace Pace	Dther conditions
	(Include pregnancy within 3 months of death)
14. Maiden name Sarah & Christian Mo.	Major findings of operations
16. Informant As allen Soften	Antopsy results
Address 17. Burial, cremstion, or removal. Which?) Date thereot (month) (day) (year)	22. VIOLENCE: It death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or secondary (Burnat, cremation, or removal, which;)	Where did injury occur?(City or town) (County) (State)
Location author md	Injured at home, farm, Industry, public place (where?)
18. Funeral director	Means of Injury Injured at work?
19. 3-7 19.47 Mus Maury & Registra	23. SIGNATURE M. D. or other
(Date 1ct d by 1cg intrat)	. Vanices de la constante de l



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PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cis especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411

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g.	Dist.	No.			4	.(1)	
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CERTIFICAT	E OF DEATH Reg, Dist. No.
1. PLACE OF DEATH County City er tewe. (If outside eif or town limits, write RURAL and give nearest town) How leng in abere place of death? Hespital, institutioe, or street address where death eccurred: How long In hospital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State
3. (a) FULL NAME Pelli Drent Commission III 4. Sex 5. Color er race 6. (a) Single, married, widower, or divorced Pennale Ahite Markild	3. (b) Social Security Number North MEDICAL CERTIFICATION 20. DATE OF DEATH. 20. DATE OF DEATH. 21. 21. 2 A. M.
6.(b) Name of humband or wife AMMAM B. P. Kinner 7. Birth date of deceased (mo., day, pr.) 4-4-2/18 96	and that I last saw h
8. AGE: Years Months Days If less than ene day 5 /	Due to Ordenie Hemontoge ? mell
10. Usual occupation of mases with 11. Industry or business, Own Tarme 12. Name Unlyana Cananana	Other conditions Orlews ?
13. Birthplace Scattand 14. Malden name Egannala 15. Birthplace V, 9/A 16. Informant July to day and Mi-Kinnse	(Include pregnancy within 3 months of death) Major findings of operations
Address Susafton Phase 17. But all 24 94 (Hurial, cremation, or removal, Which?) Date thereof Wasch 24 94 (month) (day) (year)	PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the fellowing: Accident, suicide, er hemicide
Lecation That There are the state of the sta	Injured at heme, farm, Industry, public place (where?) Means et injury Injured at werk?
19 Mark 24 19 47 Joseph G. Jak Mich (Date rec'd by registrar)	23. SIGNATURE M. D. or other M. D. or other 24 mm. 43

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MARYLAND STATE DEPARTMENT OF HEALTH

411 N. Charles St., Baltimore 93	411	N.	Chartes	St.,	Baltimore	932
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Reg. Dist. No.....

CERTIFICATE	OF	DEATH
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1. PLACE OF DEATH: County Allegasses	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborp infants give residence of mother)
	State Tud County Calgle County
City or town	City or town (If outgide sty or town limits, write RURAT, and give nearest own)
Hospital, Institution, or street address where death occurred:	Street No. 2 Glenward St.
2 Glassott D. D.	(If rural, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME Mary Docisy 7	Me Willan 3. (b) Social Security Number
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorce	MEDICAL CERTIFICATION
Temalo While Kiroccal	28. DATE OF DEATH THOUGH 20 19.47 21/0:15 PM
6.(6) Name of husband or wife the Gills his chiellen	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(c) It alive, give age 5./ years	Mar. 11. 1947 to grean 2/1947
7. Birth date of deceased (mo., day, yr.) 600 31, 1904	and that I last saw be alive on 19. F. T
8. AGE: Years Months Days If less than onn day	Immediate cause of death
7-2 6 20hrsmin.	A f
9. Birthplace Current Clown, country, and state)	Due to Chronic Wycordias (
10. Usual occupation House work	Webs-Therrondom-Rosenson
11. Industry or business At Home	Due to All
# 12. Name Samuel J. Signal	Other conditions.
12. Name James Times Tim	(Include pregnancy within 3 months of death)
14. Maiden name. Sand Coaley 15. Birthplace Centrel and The	
15. Birthplace Centileland The.	Major findings of operations
16. Informant The exist Election	Autopsy results
Address 2 glenwood St Cumberland Red	PHYSICIAN: Please anderline the cause to which death should be charged statistically.
17 Burial Date thereof March 24, 1947	22. VIOLENCE: If death was due to external causes, till in the tollowing:
(Burial, cremation, or removal, Which?) (month) (day) (year)	Accident, suicide, or homicide
0 0 1 4 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	Where did Injury occur? (City or town) (County) (State)
Location	Means of Injury Industry, public place (where?)
18. Funeral director.	means of injerior at moint
Address Churchland, Ud.	23. SIGNATURE Clays. Lucias
19. March 24, 19 47 & F. Franklin M.D	Quenterland, M. D. or other
(Date rec'd by registrar)	Address. Date signed

The State of the British the state of the state of the 2 Summer of 5 to bearing a These Thank Trucky Tola Vapidance " your Tomach litety Descreek and the design Rug 31 REGENTED -APIP 1 1947 on gride to have all Complens The father of the state of the

ADING INK. Supply every item of information carefully. The correct age Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

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1. PLACE OF DE	ATH:	7		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
County		legan	<i>(</i>			
City or town	riowa (If outside eity or town limits, write RURAL and give nearest town)			Slate Maryland county Allegany		
(lf o	outside eity or town l	Year	RURAL and give nearest town)	City or town. Cumberland (If outside city or town limits, write RURAL and give nearest town)		
How long in above place	ow long in above place of death? 80 Years 10 Days psolial, institution, or street address where death occurred:					
	09 Indeper			Street No. 209 Independence St		
***************************************				(If rural, give LOCATION)		
How long in hospital or	Institution?		***************************************	2.(a) If veteran, name war		
3. (a) FULL NAMI	E			3. (b) Social Security Number		
	Evro	Hanna	es Meders	None		
4. Sex	B. Color or race		ie, married, widowed, or divorced	MEDICAL CERTIFICATION		
	7.			MEDICAL CERTIFICATION		
Female	White	W.	idow	20. DATE OF DEATH. March 18 19 47 at 2-30		
	भ	hn III	Meders	21. I CERTIFY that death occurred on the date above stated: that I attended deceased from		
B.(b) Nams of husband	sr wifs	11111	Wedel 8	march 17 19 47 to March 17 19		
		6.	(c) If alive, give ageyears			
7. Birth date of deceased (mo., day, y	- Me	rch 8	1967	and that I last saw h. La. alive on L. M. L		
		Days	If less than one day	Immediate cause of death		
0						
80	0	10	khrs min.	WILMU		
			any Co, Maryland	Que ta HUNDINGE - COLDER		
1D. Usual occupation		House		The and the day of		
11. Industry or business		11		Oue to		
변 12. Name	John I	Buchs		Albert and these		
12. Name	Germs			Diher conditions.		
et 13. biringiace				(Include pregnancy within 3 months of death)		
里 14. Maiden name.	Mathe	rine ?	Stinebraker	Major findings of operations		
14. Maiden name.	Ger	many		major mediags of operations		
- 13. Bittipiace			3 3			
16. Informant	Mrs Mati	TOB D	LAUL	Autopsy results		
Address 20	9 Independ	ence S	St. Cumberland. Md.			
				22. VIOLENCE: It death was due to external causes, till in the following;		
17. Burial, eremation	or removal. Which?	Date the	(month) (day) (year)	Accident, sulcide, or homicide		
Cemetery or cremato	CI. T		Paul Cemetery	Whers did Injury occur?		
	(land, id.	(City or town) (County) (State)		
Location				Means of Injury / Injured at work?		
18. Funeral director	Willi	am H.	Kight	means of injury injured at moint		
Address	Cumb	erland	B. Jud.	23 SIGNATURE WELLES TOURS IN 140		
19. March	2/, 19 47	· J.	P. Fanklin M. D. Registrar	Address 108 Va. One Date signed 3/19/		

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PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carrect age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

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	CERTIFICATE OF DEATH Reg. Dist. 1	No. 40
City or town	2. USUAL RESIDENCE (HOME) OF DECEASED: (For hewborn infants give residence of mother) State	give nearest town)
3. (a) FULL NAME Mond 4. Sep 5. Color or rate 6. (a) Single, married, with	Christine metager 3. (b) Social Socia	ecurity Number
o. AGE.	ihan one day	47 at 2 47 ded deceased from 25 2 1947 deceased from 2
9. Birthplace	min Cafrio-3elerofe Hyperfuser Due to Due to	5 923.
11. Industry or business HI 12. Name Salma Wieles 13. Birthplace Cumbuland Md 14. Malden name Elizabeth Schmeider 15. Birthplace Cennamy	(Include pregnancy within 3 months of death) Major findings of operations.	
16. Informant John C : Matzgae	Autopsy results	g:
(Burial, cremation, or removal, Which?) Cemetery or crematory Location Date libereof (m) Cemetery or crematory Location	Accident, suicide, or homicide	(State)
18. Funeral director	23. SIGNATURE CASTAGES TO SOLUTION Address 1/0 5. Centre 37. Date	57c. S. M. D. or other slgned 3-22-47

APR I 1947
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2411 N. Charles St., Baltimore

E OF DEATH

Reg. Diat. No ...

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	CERTIFICA
1. PLACE OF DEATH:	
County allega	ny
City or town I and	1/-7
How long in above place of death?	limits, wite RURAL and give nearest town)
Hospital, institution, or street address when	e death occurrent.
141 Dye Can	lle St
How long In hospital or Institution?	
3. (a) FULL NAME	
79	08.
4. Sex 5. Color or race	6.(a) Single married, widowed or differed
me / 1/11	1 Bar All
Mare Home	le margad
6.(b) Name of husband or wife	sa douly middle
7. Birth date of deceased (mo., day, yr.)	3 20 - 1871
8. AGE: Years Months	Days If less than one day
75 11	/ 2
2 8	
9. Birthplace (Toy	n, county and state)
10. Usual occupation	Bridg John
11. Industry or business	
	1)-1-1-11.
12. Name 23	Park
is. Birinpiace	Jan Higa
14. Maiden name Parasa 15. Birthplace Parasa	e dourses
E 15. Birthplace Par	Pant Is, Ya
1/60	nd sprobleter
Address 141. Dage Con	Med St
B	3-7-47
(Burial, cremation, or removal. Which	Date thereof
Cemetery or crematory	garage Cerrele
Location Frestly	a Mud !
LUCATION	1 DV 1
1B. Funeral director	
Address trasle	my hid
19. 3-6. 1946	My Hauce N. 800
(Date rec'd by registrar)	- July

2. USUAL RESIDENCE (HOME) OF (For newborn infapts give residence of n	DECEASED:
State Soun	1) allegen
Cily or town(If outside city or town limits.	write RURAL and give nearest town)
Sireet No. 4 1 196 (If rural, give I	LOCATION)
2.(a) If veteran, name war	
	3. (b) Social Security Number
iddleta-	218-10-8116 RTIFICATION
MEDICAL CE	RTIFICATION
2D, DATE OF DEATH. /V/as /	1847 at // PM
21. I CERTIFY that death occurred on the date above	e stated; that I attended deceased from
	194/
and that I last saw h slive on	19.
Immediate cause of death	wollan 6 Days
	0073
- C+ - D	
Oue to arterio Stel	the state of the s
Due to	
Other conditions	
(Include pregnancy within 3 m	onths of death)
Major findings of operations	
	Date of op
Autopsy results	
22. VIOLENCE: If death was due to external cause	es, fill in the following;
Accident, suicide, or homicide	Date of
Where did injury occur?(City or town)	(County) (State)
Injured at home, farm, Industry, public place (whe	re?)
Msans of Injury	Injured at work?
11Ame	uno & ma
23. SIGNATURE OUT	M, D. or other
bothur	my my 3-3-47

UNFADING INK. Supply every item of information carefully. The correct age

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PLEASE WRITE PLAINLY

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

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hor uy

2411 N. Charles St., Baltimore CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH: ALLEGANY			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
CIMPRITAND			State WEST VIRGINIA County Mulli
City or town		its, write RURAL and give nearest town)	PURGITUSVILLE
How long in above place	of death?		(If outside city or town limits, write RURAL and give nearest town)
Hospitat, Institution, or	street address where de	ath occurred:	Street No.
		SPITAL	(If rural, give LOCATION)
How long in hospital or	Institution? 4 D.	AYS	2.(a) If veteran, name war
3. (a) FULL NAME			3. (b) Social Security Number
MR. CI	HARLES MI	LLER	None
4. Sex	5. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION
MALE	WHITE	MARRIED	20. DATE OF DEATH MARCH 23 19 47 at 10:40 P
a /b> Nama add aband	ETH:	EL BARBE	21. I CERTIFY that death occurred on the date above stated; that t attended deceased from
6.(b) Name of husband	91 H.1.6	***************************************	1. 1. 19.47 10 3 0 23. 19.44
7. Rirth date of			and that I last saw h Tagallye on 3. 73. 19642
deceased (mo., day, y	r.) APRIL	19, 1879	Immedia Cruse of death DURATION
8. AGE: Years	Months	Days If less than one day	Expense Bebilly
1 (a)	7 11	4min.	(banessaling)
	1	U. h. and	- Ren - 1 and
9. Birthplace	(Town, ed	ounty, and state)	Decito de la constante de la c
10. Usual occupationFARMER			Due to.
11. Industry or business	s		
H 12 Name	CHARLES M	ILLER	Other conditions the transfer count
13. Birtholace VIRGINIA			(Missames a D to the
			(Include pregnancy within 5 months of death)
14. Maiden name 15. Birthplace			Major findings of operations Courting TE.
S 15. Birthplace	VIRGI	NIA	Banks Date of op.
	EMORIAL H	OSPITAL	Appen results. A ZL D TE
O. INTORMANT.			PHYSICIAN: Please moderline the cause to which death should be charged statistically.
Address	COMPENDA	Su 1 - 1 1011 -	22. VIOLENCE: If death was due to external causes, fill in the following:
(Burial, cremation, or removal, Which?) Date thereof. Att. CM 2 C 1947 (month) (day) (year)			Accident, suicide, or homicide
AM H. Chulak			
Cemetery or crematory.			Where did injury occur? (City or town) (County) (State)
Location Telas Purgettserlle W. Ja.			Injured at home, farm, Industry, public place (where?)
18. Funeral director			Means of Injury Injured at work?
			12 4. W. 21.
Address MOOREFIELD, W.VA.			23. SIGNATURE M. Door other,
19 March 2518 47 V. K Franklin, M.A			M. Doorother
(Date rec'd by registrar)			Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (necorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

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M. D. or other Date signed 3/3/1/27

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The long is well as	City or town
3. (a) FULL NAME Mary &	ta minniche
4. Sex 5. Color or race 6. (a) Single, married, with Ferral Collie Types 8. (b) Name of husband or with 8. (c) Maller Single 8. (d) Maller Single 8. (e) Maller Single 8	20. DATE DF DEATH
7. Birth date of deceased (mo., day, yr.) 8. AGE: Years wonths Days It less to	and that I last saw h. 2
11. Industry or business Ot House	Due to News
12. Name John Hatse 13. Birthplace 14. Malden name Martha Horth 15. Birthplace Muknor	Other conditions
16. Informant. Jesus Tolkers Harris Address 429 Duy Chemicas	Antopsy results
(Burial, cremation, or removal, Which?) Cemetery or crematory	Accident, suicide, or homicide. Where did injury occur? Injured at home, tarm, industry
18. Funeral director John Jacobs Address Address	Means of Injury 2.23. SIGNATURE
19. (Date rec'd by registrar)	Registrar Address 101 Ac

2. USUAL RESIDENCE (HOME) OF	DECEASED:	
= 11	y allegans	**
City or town	write RORAL and give nearest town)	
1-00	Jacadeure S	
2.(a) If veteran, name war	y	
1 0	3. (b) Social Security Number	
innicks	none	
MEDICAL CE	RTIFICATION	
20. DATE OF DEATH March	28 1947 11 71001	1
21. I CERTIFY that death occurred on the date above	e stated; fhat Lattended deceased from	
8/26-147	to 128/47 19	
and that I last saw h. Stammailve on	2/27 19	
Immediais cause of Really	DURATION	
John Town	as mes 6 chan	1

Due to	Milsel	
	9.1	
Due to Must diss	Mala.	
Other conditions		
(Include pregnancy within 3 m	onths of death)	
Major findiage of operations		
Major indiage of operations.	Date of op	
Many Many	Sele of op.	
Antopsy results. PHYSICIAN: Please underline the cause to whi	ich death should he charged statistically.	-
22. VIOLENCE: If death was due to external caus	ies, fill in the following;	
Accident, suicide, or homicide	Date of	•••
Where did Injury occur?(City or town)	(County) (State)	
Injured at home, tarm, industry, public place (who	ere?)	
Means of Injury	Injured at work?	
/ Auto	111	
/ NIVIUN	11	

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ADING INK. Supply every item of information carefully. The c Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9:30

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn in fants give residence of mother)
County allegant	State This county allegans
City or town (If outside city or town limits, write RURAL and give nearest town)	Tut Severa 0 1
How long in above place of death?	(If outside city or town limits, write dURAL and give nearest town)
210 = Knoy St.	Street No. (If rural, give LOCATION)
Now long in hospital or institution?	2.(a) It veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Mis Janisa Mo	ut. Mone
4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Female White Widowed	20. DATE OF DEATH WASCL 20 19.47 at 9:08 P
6.(b) Name of husband or wife tolas w month	21. I CENTIEY that death occurred on the date above stated; that I altended deceased from
6.(c) If alive, give ageyears	March 20 19 4 7 10 Knowle 20 19 4-7
7. Birth date of deceased (mo., day, yr.) Mary 14, 1863	aed that I last saw h alive on
8. AGE: Years Months Days It less than one day	Immedia; cause of death
83 10 6hrsmin.	
9. Birtholace Carlisla Cumberland Co Engla	Due to As fishing board and
(flown, county, and state)	1 dream years
1D. Usual occupation.	Due 10
11. Industry or business	
12. Name 13. Birthplace	Dther conditions
	(Include pregnancy within 3 months of death)
14. Maiden name	Major findings of operations.
El 15. Birthplace Euclipean	Date of op.
16. Informant Mass Mangarious Christian	Autopsy results
Address 409 Lebigh St Cumb Myd	
17 Birral Date thereof Mar 23, 1947	22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide
(Burial, cremation, or removal, Which?) Date thereot	
Cemetery or crematory.	
Location	Injured at home, farm, Industry, public place (where?)
18. Funeral director	Great of minity
Address / Cumperland, and.	22 SIGNATURE T. Clany llungles
10 March 22,047 J. P. Janklin M.D.	M. Ily or other
(Date rec'd by registrar)	Address Landu Date signed Date signed

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correct age

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MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

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CERTIFICATE OF DEATH

ist No. 4

	Reg. Dist. No.
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) MARYLAND State FROSTBURGS City or town (If outside city or town limits, write RURAL and give nearest town) Street No. R.F.D. #I (Gilmore) (If rural, give LOCATION) 2.(a) If veteran, name war.
3. (a) FULL NAME MR.JOHN T. MOORE	3. (b) Social Security Number 2/5-07-0372.
MALE Scotor or race 6.(a) Single, married, wildowed, or divorced MARRIED	MEDICAL CERTIFICATION MARCH 7,1947 1;48 A.M.
6.(b) Name of husband or wite	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. 10. 19. 19. 19. 19. 19. 19. 19. 4.7 Immediate cause of death. Arterio sclerotic, cardio several vascular, renal disease Due to. (autopsy findings) Due to. Pulmonary edema, marked cerebral edema & myocardial Other conditions. degeneration. (Include pregnancy within 3 months of death) Major findings of operations.
16. Informant Mas Helda Autory Address Filmers Anosthrug R. F. 3. 1-1118 17. Burial pate thereof Mass 9. 1947. (Burial, cremation, or removal Which?) Cemetery or crematory Allegany Councilery, Location Filmers Dackburg Mass 18. Funeral director Mass Surgery Mass Address Surgery Mass 19. March 9. 19. 4. Typicaling M. Pegistras 19. March 9. 19. 4. Typicaling M. Pegistras	Actopsy, results. Bate of op. Actopsy, results. Bate of op. Actopsy, results. Actopsy, results. Actopsy, results. Bate of op. Actopsy, results. Actopsy, results. Actopsy, results. Actopsy, results. Bate of op. Actopsy, results. Actopsy, results. Actopsy, results. Actopsy, results. Bate of op. Actopsy, results. Actop



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



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7.	Diat.	No.	70

DURATION

CERTIFICATE OF DEATH 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) County allevan (If outside city or town limits, write RURAL and give nearest town City or town. How long in above place of death?..... Hospital, Institution, or street address where death occurred: (If rural, rive LOCATION) How long in hospital or institution?. 2.(a) I1 veteran, name war 3. (a) FULL NAME 3. (b) Social Security Number MEDICAL CERTIFICATION 20. DATE OF DEATH. 21. I CERTIFY that death occurred on the date above stated; that Lattended deceased from 6.(b) Name of husband or wife. 8.(c) 11 alive, give age 7. Birth date of deceased (mo., day, yr.) 8. AGE: 0 (Town, county, and state) 10. Usual occupation... 11. Industry or business 13. Birthplace (Include pregnancy within 8 months of death) 14. Maiden name. Major fiediers of operations. 15. Birthplace PHYSICIAN: Please ooderline the caose to which death shoold be charged statistically. 22. VIOLENCE: It death was due to external causes, till in the following: (month) (day) (year) Accident, suicide, or homicide..... Where did Injury occur? (City or town) (County) Injured at home, farm, industry, public place (where?) Injured al work? Msans of Injury 23. SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH

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				TE OF DEATH	Reg. Dist. No	40
1. PLACE OF DEATH: County			2. USUAL RESIDENCE (HOME) (For newborn infants give residence) State Maryland City or town Cumberland (If outside city or town line)	County Allegany		
Hospilal, institution, 192	Rear Wine	ow St		Street No. 192 Rear Wir	neow St.,	
			***************************************	Z.(a) II veteran, name war		
3. (a) FULL NAM		1 Mur	phy		3. (b) Social Security 2 20 - 10 -	
4. Sex	5. Color or race	6.(a)Singl	e, married, widowed, or divorced	MEDICAL	CERTIFICATION	1
Male	White	9	ingle	20, DATE OF DEATH March 26,	19. 47	4:001
w at the data at	•••••	6.(c) It alive, give ageye	21. I CERFIFY that death occurred on the date	above stated; that lattended dece	eased from
8. AGE: Yea	yr.) Unknown or Months	Days	If less than one day	Immediate cause of death.	nyocarett	DURATION
10. Usual occupation	B & C	rker R.	R. Co.	Due to Due to Other conditions	selvani.	¥+ 9u,
13. Birthplace	Ireland			(Include pregnancy within		
16. Intermant	r. David		y	Autopsy results	Date of op	statistically.
17 Buria	n, or removal, Which?	Date ther	t. Cumberland Mar. 28, 19 (month) (day) (year)	22. VIOLENCE: If death was due to external Accident, sulcide, or homicide	l causes, till in the tollowing:	
Location Cu	mberland,	Md.	α Paul Cem.	Where did Injury occur?(City or tow	e (where?)	(State)
	Charles mberland,		eorge	41	injured at work?	(8,
19 Muse (Date rec'd by	127, 19 4	1	P. Fanklin M. Regist	23. SIGNATURE 33 V Ca	M. D. Quae Date signed.	or other



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MARYLAND STATE DEPARTMENT OF HEALTH

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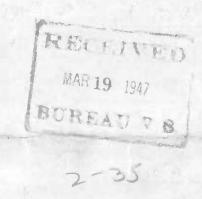
2411 N. Charles St., Baltimor-

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CERTIFICATE OF DEATH Re

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۲.	Dist.	No	· · · · ·

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Alleyson	
(If outside city or town limits, write RURAL and give nearest town)	State Many Lyd county alleyons
	City or town
How long in above place of death?	
Automas Orme	Street No. Auteman Drive (If rural, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Since Kune Nicoll	Hone
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION 89/
F W Willowell	211.112 47 6/1
10 000 000	20. DATE OF DEATH. 21 6/9 M
6.(6) Name of husband or wife William Wicoll	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
0.(o) frame of hoseans of kilotin	1-1-1946 10 3-10 194/
7. Birth date of San	and that I last saw halive on
deceased (mo., dey, yr.) September 9, 1872	Immediai/cause of death
8. AGE: Years Months Days If less than one day	Clasury artery Resease 3 7/6
7 4 6 hrsmin.	Chail myrebylete by
e Richardes newsons M.J.	
9. Birthplace (Town, eounty, and state)	Due to Co Co Solerono 10 m
10. Usuat occupation harmagnatule	
	Due to
11. Industry or business	
12. Name Lynna Kine	Other conditions
12. Name Lynna Kine 13. Birthplace New Jensey	
# 14. Maiden name anna wan	(Include pregnancy within 3 months of death)
	Major findings of operations.
2 15. Birthplace New Jansey	Date of op.
16. Informant Mr. D. W. Seymour	Actopsy results
	PHYSICIAN: Please underline the cause to which death should be charged statistically.
Address dutemon Drive, Cumbuland, Md.	22. VIOLENCE: It death was due to external causes, till in the tollowing;
17. (Burial, cremation, or removal, Which?) Date thereof. (month) (day) (year)	Accident, suicide, or homicide
	700
Cemetery or crematory. Lumnout Connetting	Where did injury occur?
Location neural N. J	injured at home, farm, industry, public piace (where?)
2 Str. 1	Weens of Injury Injured 2t work?
18. Funeral director	Att Re No
Address Cumbaland 1911 -	as construer of the contract of the
Marchin 112 Oftable MIX	23. SIGNATURE.
(Date rec'd by registrar) Registrar	Address Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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	Dist.		11	1
Reg.	Dist.	No.	7	

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Allegany	State Md. County Hilegary
(If outside city or town limits, write RURAL and give nearest town)	1 1 1 ~ ~ ~
How long in above place of death? 33 years	City or town County or town limits, write RURAL and give nearest town)
Hospital, institution, or street address where death occurred:	Street No. 473 Baltimore Ave,
473 Baltimore Ave.	(If rurat, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war.
3. (a) FULL NAME	3. (b) Social Security Number
Catherine L. Norris	none
4. Set 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
F W Morried	20. DATE DE DEATH MAY 6 14, 1947 21/2:10 P.
6.(b) Name of husband or wife Maurice F. Morris	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
	mont. 10 1847 10 March 14 18/
7, 8irth date of	and that I last saw h exalive on Microch 14 15/7
deceased (mo., day, yr.) Tune 23, 1913	Immedian cause of death DURATION
8. AGE: Years Months Days If less than one day	Telleray Leberculisis 8 ms
33 8 2/hrsmin.	
9. Birthplace Cumber land, Fille gany, Md.	Due to
10. Usual occupation. House ife	Due to
11. Industry or business Own home	
12. Name Inha Tr. Knipponborg	Dther conditions
13. Birthplace Jaring Gap, Md.	(Include pregnancy within 3 months of death)
14. Maiden name Rase M. Kiiffner 15. Birthplace Comberland, Md. 16. Interment Maurice F. Norris	(Include pregnancy within a months of death) Major findings ol aperations
15. Birtholace Cum per land. Md.	Date of op.
16. Interment Maurice F. Norris	Antoney Pesuits
Address Comberland, Md.	PHYSICIAN: Please underline the cause to which death should be charged statistically.
	22. VIOLENCE: If death was due to external causes, lill in the following:
17. But ial Bate thereof Marc 17, 1947 (Burial, cremation, or removat, Which?) (Burial, cremation, or removat, Which?)	Accident, suicide, or homicide
Cemetery or crematory Hillerest Cemetery	Where did injury occur?
/ / / /	Injured at home, farm, industry, public place (where?)
Location Comberland, Md.	
18. Funeral director At Land As Ho fee	Means of Injury Injured at work?
Address Commented und.	20 SIGNATURE Season aid.
Manden us Paralli ma	23. SIGNATURE M. D. or other
(Date fee'd by registrar)	Address Date signed 777/4)

MAR 25 1947

MAR 25 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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			CERTIFICAT	TE OF DEATH	Reg. Dist. No.	******	
City or town(If How long in above pla Mospital, institution,	Coutside city or town I	umber imits, write F 1 day death occurred ospita	1	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland County Allegany City or town Cumberland (If outside city or town limits, write RURAL and give nearest town) Street No. 610 Hill Top Drive (If rural, give LOCATION) 2.(a) If veteran, name war.			
3. (a) FULL NAM			, O'Brien		3. (b) Social Security Number		
Male Male	5. Color or race White		e, married, widowed, or divorced	MEDICAL 20. DATE OF DEATH	CERTIFICATION 30, 19 47 at /	134	
	yr.) Apr1		(*) Brien (*) If allve, give ageyears (*) 864 If less than one day	and that I last saw h	18 4 10 March 30	1947 1947 URATION	
12. Name	Bo11	R.R. Brien	cer-Rehied	Due to			
15. Birthplace	Irela	and	her	Major findings of operations			
Address 610	Hill To	Date ther	Cumberland, Md eof Apr. 2,1947 (month) (day) (year)	PHYSICIAN: Please underline the cause to 22. VIOLENCE: If death was due to external Accident, suicide, or homicide	which death should be charged statistical causes, fill in the following;		
Location	Cumbe	rland	Cem. Md. Heorge	Where did Injury occur?(City or town injured at home, farm, Industry, public place Means of Injury	(where?)		
	Cumber	ha fa	Ma		1	100	

23. SIGNATURE.

Registrar Address..

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(Dayle rec'd by registrat)

WATH UNFADING INK. Supply every item of information carefully. The correct important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32-0

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			TE OF DEATH	Reg	Diat. No. 4	
City or town	of death?	nd its, write RURAL and give nearest town) sath occurred:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Maryland Couoty Allegany Rural (Fairgo) Cumberland (If outside city or town limits, write RURAL and give nearest town) Street No (If rural, give LOCATION) 2.(g) It veteran, name war.			
3. (a) FULL NAM	E		<u> </u>	3. (b) S	ocial Security Number	
	Albert	Edward Phillips		N	one	
4. Sex Male	5. Color or race White	6.(a)Single, married, widowed, or divorced Single		CAL CERTIFIC	ATION 47 8:	10P.
	or witeNone		21. I CERTIFY that death occurred on	19. 4.7., to	3-22	19
7. Birth date of	Mar. 30		and that I last saw hsalive)n	27-	19. 4.
8. AGE: Years	Months	Days It less than one day 22hrsmin.	Immediair cause of death	n		URATION Dec
9. BirthplaceCun 10. Usual occupation	Infar	Allegany Maryland punty, and state) 1t	Due to	ya.		
13. Birthplace	erome Phil	Md.	Dither conditions	cy within 3 months of de	ach)	
14. Maiden name.	Marie Mi Bedford V	Iller Valley, Penna.	Major findings of operations			
16. Informant	CI OMC III.	llips perland, Md.	Autopsy results PHYSICIAN: Please underline the canse to which death should be charged statistically.			
17. Burial (Burial, cremation	P.O.S. of	Date thereof Mar. 25, 1947 (month) (day) (year) A. Cem.	22. VIOLENCE: It death was due to Accident, suicide, or homicide Where did Injury occur?		Date of	,
Location Cer	ntreville	Penna.	tnjured at home, farm, Industry, pub			
18. Funeral director	H. Wayne	George	Means of Injury	1nju	ared at work?	
Address	Cumberlar		22 SIGNATURE LOS	all by luc	resuman hel	0
19. Males Ch. (Date rec'd by re	24, 19.47	J-P. Tranklin, M.L. Registrar	Address Cresaptour	1 0	M. D. or other Date signed 3-2	
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH: De la Clegary	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County	State Maruland County allegany
(If outside city or town limits, write RURAL and give nearest town)	2-11
How long in above place of death?	(If outside city of town limits, write RUPAL and give nearly town)
48 Mechanic H.	Street No. T. J. (If rural, give LOCATION)
How long in hospital or institution?	2.(a) It veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
William Riger	none
4. Sex 5. Color or race 6.(a) Single, married, yidoyled, or divorced	MEDICAL CERTIFICATION
male white married	20. DATE DE DEATH. Mas 17 1947 at 60 A M
6, (b) Name of husband or wife Daraly Ringer	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(c) If alive give ageyears	Fel 22 15t 7, 10 Mar 17 19 42
7. Birth date of 25 1915	and that I last saw back alive on Feb. 28 1947
deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day	Immediate cruse of death
81 60 19min.	Chr. myseus and your
To the sa College with the	- ASTAL SULLAND
9. Birthplace (Toyn, county, and state)	Due to
10. Usual occupation.	Dua to.
11. Industry or business Trickyard	544 (4
E 12. Name Dimone Ringer	Dither conditions
12. Name	(Include pregnancy within 3 months of death)
14. Malden name New rietta Holtzman	
15. Birtholace Wiknown	Major findings of aperations
16. Informant Mrs. Walter Riser	Autopsy results.
Address Front lours and.	PHYSICIAN: Please underline the cause to which death should be charged statistically.
Burnial I'a in ion	22. VIOLENCE: It death was due to external causes, till in the tollowing;
17 Date the lea	Accident, suicide, or homicide
Cemetery or crematory. Allegacy Circlery	Where did Injury occur? (City or town) (County) (State)
Location Tresthika and	Injured at home, farm, industry, public place (where?)
18. Funeral director. R. Russet	Means of Injury Injured at work?
Address In atherna Md.	22 SIGNATURE NOM Jane & M
2 2 WALL XIP	M. D. or other
(Date red by registrar) (Date red by registrar) (Date red by registrar)	Address Frostling my Date signed Mail 1844)

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WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83 2

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		CERTIFICA	Reg. Diat. No.		
1. PLACE OF DEA	A	llegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
City or town. Cumberland		5 Years	State Maryland county Allegany City or town (If outside city or town limits, write RURAL and give nearest town)		
	1340 Shad	es Lane	Street No. 1340 Shades Lane (If rural, give LOCATION)		
How long in hospital or	Institution?		2.(a) If veteran, name war.		
3. (a) FULL NAME	Mattie	Dallas Robertson	3.(b) Social Security Number None		
4. Sex	5. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
Female	White	Widow	20. OATE OF OEATH		
T. Birth date of	***************************************	liam Francis Robertson 6.(c) If allive, give ageyears	21. I CERTIFY that death occurred on the date above stated: that I aftended deceased from 18. 4. 10. 4. 15. 19. 4. and that I last saw he laive on		
deceased (mo., day, pr. 8. AGE: Years	Months	Days It less than one day	Immediate cause of death		
68	3	23hrsmin.			
9. Birthplace Fli:	ntstone, A	llegany Co, Maryland ounty, and state)	Que fa		
		House	Due to		
11. Industry or business		B. Banks tstone, Md.	Other conditions.		
	Mary	Jane Kline	(Include pregnancy within 8 months of death) Major findings of operations.		
15. Birthplace	Flin	tstone, ld.	major madings of operations. Date of op.		
16. Intermant	Mrs Ora M	ae Lewis	Autopsy results		
		ne, Cumberland, Ma.	22. VIOLENCE: If death was due to external causes, till in the following;		
(Burial, cremation,	or removal. Which?)	Oate thereof 3/19/47 (month) (day) (year) 1 Crest Cemetery	Accident, suicide, or homicide		
		rland, Md.	Injured at home, farm, Industry, public place (where?)		
		H. Kight	Means of Injury Injured at work?		
Address	Cumberla		23. SIGNATURE Bailey Gunter My		
19. March	19 19 4 7	L. J. Franklin, M. L. Registral	Address Ceembertand M. D. or other Address Ceembertand M. D. ar other		

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PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

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Reg.	Diat.	No.	 		

	2411 N. Charle	s St., Baltimore	
	CERTIFICAT	TE OF DEATH	Reg. Dist. No.
1. PLACE OF DEATH: County		City or town	mother) inity
How long in hospital or institution?	······································	2.(a) If veteran, name war	
3. (a) FULL NAME Sara Paters	n Roeme		3. (b) Social Security Number
	d, widowed, or divorced	MEDICAL C	ERTIFICATION
F W WG	Lourd	20. DATE OF DEATH March	20 1947 2:30
6.(b) Name of hueband or wife Chose Roamer 6.(c) If all videceased (mo., dey, yr.) April 28, 1867		21. I CERTIFY that death occurred on the date about 19: and that I last saw h	11 7000 (10)
o. Aue:	ss than one dayhrsmin.	Due to	V. Heren yea
11. Industry or business			
12. Name andrew Successey 13. Birthplace Wash VA.		Other conditions	***************************************
13. Birthplace West VA. 14. Maiden name Manie Harris 15. Birthplace West VA.		(Include pregnancy within 8	
16. Informant andnew Sweening Rose Address 125 N. Centry St. Cyr	mer whilm MI.	Autopsy results	chich death should be charged statistically.
17	(month) (day) (year)	22. VIOLENCE: If death was due to external ca	Date of
Cemetery or crematory Greenwood Comple Location Wheeling Work Virg	0	Where did injury occur?(Gity or town) Injured at home, farm, industry, public place (where?)
18. Funeral director day is String Inc. Address Cumbuland Mal	The Lli m 2	Meane of injury 23. SIGNATURE	Injured at work?

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information carefully. The correct of death clearly and legibly.

UNFADING INK. Supply every item of causes. Physicians: please write the causes

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1222

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Reg. Diat. N	.02492
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			CERTIFICAT	E OF DEATH	Reg. Diat. No.	
1. PLACE OF DE				2. USUAL RESIDENCE (HOME) 0 (For newborn infants give residence of		
			RAL and give nearest town)	17-1-1 Misson	s, write RURAL and give nearest town)	104
Hospital, Institution, of Allegar	or street address where day Hospita	eath occurred:		Street No	s, write RURAL and give nearest town)	
How long In hospital	or institution? 4 I)ays	**************************************	2.(a) It veteran, name war		
3. (a) FULL NAM					3. (b) Social Security Number	
	Ruzycki) C (a) Single	married, widowed, or divorced		laste	
4. Sex Male	White		ngle		ERTIFICATION L 15, 18 4 7, at	M
	d or wite			21. I CERTIFY that death occurred on the date ab		
7. Birth date of deceased (mo., day,	IInlmou		If allve, give ageyears	and that I last saw halive on	DURATION DURATION	_
8. AGE: Yea	rs Months	Days	it less than one day	Trougulate		******
11. Industry or busine	Retired M	ner		Due to		
13. Birthplace	Unknown "			Other conditions	months of death)	
14. Maiden name	11			Major findings of operations.	Date of op.	
	cs.Joseph khart Min		en .	Autopsy results	hich death should be charged statistically.	
17	on, or removal. Which?)	Date there	March 18 1947	22. VIOLENCE: If death was due to external ca Accident, suicide, or homicide Where did injury. occur?	Date of	
Location Frostburg, Md.		Injured at home, tarm, industry, public place (******		
18. Funeral director.	Jacob Haf East Main	Stree	t Frostburg, Mc	Meens at Injury Neens at Injury Rece X 23. SIGNATURE	! Porum 4 D	
19. Marco (Date ree'd by	18,19 47	J. 1	Franklis M.D.	has Da	ud he Date signed 3/17/4	47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

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OF DEATH

CERTIFICAT	E OF DEATH		
1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DEC (For newborn infants give residence of mother State Maryland County Cumberland (If outside city or town limits, write Street No. 303 Harrison Street (If rural, give LOCA 2.(a) If veteran, name war.		
3. (a) FULL NAME **Atte profitore 4. Sep	Schaffer 3. Schaffer 120. Date of Death 120.		
6.(c) Name of husband or wite Olsan M. Schaiffle 7. Birth date of deceased (mo., dey, yr.) for 76 186 7 8. AGE: Years Months Days If less than ooe day hrs. min.	21. I CERTIFY that death occurred on the date above state and that I last saw h		
9. Birthplace	Due to		
13. Birthplace Virginia Shobe Sh	(Include pregnancy within 3 months Major findings of operations. Autopsy results.		
Address 303 Harrison St., Cumberland, Md. 17. Burial (Burial, cremation, or removal, Which?) Cemetery or crematory Indian Mound Cemetery	PHYSICIAN: Please underline the eause tu which de 22. VIOLENCE: If death was due to external causes, til Accident, suicide, or homicide		
Location Romney, West Virginia. 18. Funeral director Louis Stein, Inc. Address Cumberland, Maryland. 19. Maryland. (Date ree'd by registrar) (Date ree'd by registrar)	Injured at home, tarm, Industry, public place (where?) Msans of Injury 23. SIGNATURE Address.		

State MaryLand	county Allegany	• • • • • • • • • • • • • • • • • • • •
City or town Cumberland (If outside city or town lim	nits, write RURAL and give near	est town)
Street No. 303 Harrison (Ifrural, gi	Street	
2.(a) If veteran, name war		
0111	3. (b) Social Security N	umber
Schaubler	None	
//EDICAL	None CERTIFICATION	. 7
20, DATE OF DEATH MAN	29 1947	4
21. I CERTIFY that death occurred on the date		
march 28	9. 4.7. 10. March	7 19 /
and that I last saw halive on	work of	DURATIDI
Chronic My	A.T.	Source
Due to.	p	
Due to farmilie	1 asth	•
Due to		***************************************
	•••••••	
Dther conditions		
(Include pregnancy within	3 months of death)	
Major findings of operations		
Major findings of operations	Date of op.	

here did Injury occur?(City or town) ured at home, tarm, Industry, public place (where?) sans of Injury Registrar Address.

Injured at work?

(County)

SIGNATUR

or spechard Millians

APR 5 1947

RECEIVED

MAR 21 1947

correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93%

02395

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
county Allegany	State Md county Allegany		
City or town	City or town. Cumberland (If outside city or town limits, write RURAL and give ne		
How long in above place of death?			
Hospital, Institution, or street address where death occurred:	Street No. 247 N. Center St. (If rural, give LOCATION)		
How long in hospital or institution?	2.(a) If veteran, name war		
3. (a) FULL NAME	3. (b) Social Security		
	Mars		
Mrs. Sarah Helen Stark 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
Female White widow	2D. DATE DF DEATH March 1947	.11.45P	
6.(b) Name of husband or wife John Frank Stark	21. I CERTIFY that death occurred on the date above stated; that I attended deco		
7. Birth date of	and that I last saw h.er. all Dead March 2		
deceased (mo., day, yr.) Sept. 24, I880	Immediais cause of death		
	Chronic Myocarditis	several	
5 6 5 7hrsmin.			
9. Birthplace Vale Summitt, Md. (Town, county, and state)	Due fo. arterio-sclerosis	-	
10. Usual occupation House Wife		******************************	
11. Industry or business	Due to	**	
	Riber conditions	**	
12. Name Frank Mc Mahan 13. Birthplace Ireland			
	(Include pregnancy within 3 months of death)		
14. Maiden name Mc Millan 15. Birthplace Ireland	Major findings of operations.		
	Date of op		
16. Informant Philip Stark	Autopsy results	statistically.	
Address Cumberland, Md.	22. VIOLENCE: If death was due to external causes, till in the following;		
17. Burial Date thereof March 5.47 (Burial, cremation, or removal. Which?)	Accident, suicide, or homicide		
Cemetery or crematory St. Patricks	Where did injury occur?		
tocation Cumberland, Md.	Injured at home, farm, industry, public place (where?)		
	Meaos of injury Injured at work?		
18. Funeral director Louis Stein Inc.	deputy medical Examiner - Alle	gany Ca	
Address Cumberland, Md.	23. SIGNATURE H.V. Deming M.D. H. U. D.	ing ma-	
19. March 4, 1947 J. P. Franklin, M. Date rec'd by registrar	Address Culved M. D. Date signed		

PLEASE WRITE

A15 SA

RECEIVED

MAR 11 1947

BUREATI 1 5

BINDING

FOR

RESERVED

MARGIN

1. PLACE OF DEATH!

3. (a) FULL NAME

6.(b) Name of husband or wife

Yeare

(Burial, cremation, or removal, Which?)

7. Birth date of deceased (mo., day, yr.)

10. Usual occupation

11. Industry or business

13. Birthplace

14. Maiden name.

Address

Cemetery or crematory

(Date rec'd by registrar)

18. Funeral director

Address

8. AGE:

(If outside eity or town liphts, write RURAL and give nearest town)

Days

(Town, county, and state)

6.(a)Single, married, widowed, or divorced

If less than one day

3-

(month) (day) (year)

23. SIGNATURE.

Date thereof.

5. Color or race

Months

0

City or town.

4. Sex

LD 9.45.15M

VS A15

PLEASE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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211101

CERTIFICATE OF DEATH

02396

OF DEATH	Reg. Dist. No	9
2. USUAL RESIDENCE (HOME) C	OF DECEASED:	
State 29 di Co	ounty	annag.
City or town	ts, write RUBAL and give nes	rest town)
Street No. 09 - 6 . 270 2	LOCATION)	1 1
2.(a) If veteran, name war	/	
Stale	3. (b) Social Security	Number
MEDICAL C	ERTIFICATION	
20. DATE OF DEATH THANK	11 7 1947	1 4°4
21. I CERTIFY that death pecurred on the date ab	7 4 4 4 4	2 19. 47.
and that I last eaw hC. alive on	DATE OF I	19.44.7.
Immediate cause of death		DURATION
Cronary accu	clary	1 day.
Due to Pleuring.		2 days
Due to	***************************************	
	•••••	
Other conditions		
(Include pregnancy within 3	months of death)	
Major findings of operations	***************************************	************
	Date of op	
Autopsy results	which death should be charged	statistically.
22. VIOLENCE: If death was due to external ca	auces, fill in the following:	
Accident, suicide, or homicide	Date of	***************************************
Where did injury occur?(City or town)	(County)	(State)
Injured at home, farm, industry, public place (where?)	••••••
Menne of Injury	Injured at work?	
() () () ()	Name of the last	- 100 S

Jattens HET DOWN epparelial of a Con E 12 while I have a former Come of thembon reti Floren RECEIVED MAR 11 1947 BUREAU F & 1-35

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. She

WRITE

PLEASE

A15

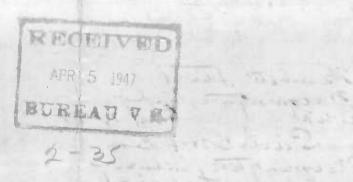
MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH: County. A LLEGANY	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
CUMBERLEND	MARYLAND County ALLEGANY		
	MESTERN PORT		
How long in above place of death? 6 DAYS	(if outside city or town limits, write RURAL and give nearest town)		
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITIAL	Street No. 103 MAIN STREET		
6 DAVE	(If rural, give LOCATION) 2.(a) If veteran, name war		
now long in nospital or institution:			
3. (a) FULL NAME	3. (b) Social Security Number		
CARRIE STOLL	None		
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
FEMALE WHITE MARRIED	20. DATE DE DEATH. MARCH 29, 19 47 21 7.00P		
6.(b) Name of husband or wife WILLIAM 7. Stoll 68	21. I CERTIFY that death occurred on the date above stated; that I allended deceased from 22 Mar. 19.4.		
7. Buth date of	and that I last saw h. A. alive on = 9 Mor 4.7 19		
deceased (mo., day, yr.) JULY 23, 1877	Impediately of death DURATION		
8. AGE: Years Months Days If less than one day	Strome Nobbatio		
69 8 6hrs. min.	(Internal)		
Ihmb Haven Penua			
9. Birthplace (Town, county, and state)	Xero Zio		
1D. Usual occupationHOUSEWIFE			
	Due 10.		
11. Industry or business			
12. Name MEARS, JAMES 13. Birthplace Unknown	Dither conditions		
13. Birthpiace Wiknows	(Include pregnancy within 3 months of death)		
H 14. Maiden name SMITH, ISABELIA 15. Birlhplace Uyknowy	71 - 2		
E sixtheless land marches	Major findings of operations.		
.78	Dale of op.		
16. Informant de de de la	PHYSICIAN: Please underline the cause to which death should be charged statistically.		
Address Wilmington Dely			
	22. VIOLENCE: If dealh was due to external causes, fill in the following;		
(burial, cremation, or emoval. Which?) Dale thereof A (month) (day) (year)	Accident, suicide, or homicide		
Cemetery or crematory with Stoute Comments	Where did injury occur?		
Localion I love of toro Delivere	Injured al home, farm, industry, public place (where?)		
18. Funeral director Ellewatte & Soul	Meens of injury injured al work?		
Address Wistonen brief 2016-	X1 + \(\) 101 = 2		
De la Santa de la Contra de la	23. SIGNAFURES M. D. or other		
(Date rec'd by registrar)	Addres Sumbel sy Date signed 3/3 to for		



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And a constitution of the second

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STHEBIRTH
flad within 24 hours for every still birth of 20 weeks' gestati

/	A certificate must be filed within 24 hours for ever,	, Striff	birth of 20 weeks Bestation of more (see stub)
1.	County Allegheny City or town Cumberland (If outside city or town limits, write RURAL and give nearest town) Street address, hospital, or institution: Length of mother's stay in County (How many years, or months, or days. SPECIFY WHICH)		USUAL RESIDENCE OF MOTHER: State Maryland County Alloghany Cresaptown City or town Cresaptown (If outside city or town limits, write RURAL and give nearest town) Street No. (If RURAL give LOCATION)
3. 5.	Name of child. Sex. Male 6. Twin or triplet.	1	Date of birth March 31, 1947 Hour 12:45 am. No. of weeks pregnancy 4 1/2 mos.
9.	FATHER OF CHILD Full nameRay.Elwood.Stouffer Color. white 10. Age at time of this birth29 yrs. Usual occupationspinner, celanese.corp.	13.	MOTHER OF CHILD Full maiden name. Mary Elizabeth Witt Color White 14. Age at time of this birth 25 yrs. Usual occupation. Mt. Savage, Md hswf.
16. 17. 18.	Other children born to mother (not including present child) (b) How many other children were born alive but are now determined to be child die before labor? During labor? Pregnancy, complications of	21.	
19.	Labor: (a) Complications of	22.	(a) Fetal causes (b) Maternal causes I certify to the birth of this child who was born dead* on the date and hour above stated. Signature (Specify if M. D., midwife, or other)
	(a) (b) Date thereof (month) (day) (year) (c) Cometery or crematory. (a) Funeral director (b) Address * See Instruction C on stub.	25.	(a)(Date rec'd by registrar) (b)(Registrar) (To be filled out if no physician was present at delivery.) The above certificate has been examined by me. Health Officer, per
/	Baby expired 2 h. & 45 m. after birth		



STATE OF THE STATE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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02398
Reg. Dist. No. 40

				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
County Allegany Cumberland			***************************************	state Maryland County Allega	nv	
City or town			URAL and give nearest town)			
How long in above place of death? 18 years			ırs	City or town Rt. 6. (Potomac Park)	e penrest town)	
Mospilal, Institutioe, or etreet augress where death occurred:			i.	Street No. Near Cumherland, Rural		
Allegany Hospital			1	(If rural, give LOCATION)		
How long in hospital or institution?			78	2.(a) If veleran, name war		
3. (a) FULL NAME				3. (b) Social Secu	rity Number	
			Strawser	214-07-19	94.5	
4. Sex	5. Color or race	6.(a)Single	e, married, widowed, or divorced	MEDICAL CERTIFICATION		
Male	White		Married	20. DATE OF DEATH. March 5 19.4	7 at 8-55 Am	
B.(6) Name of husband or wife Florence Heckert				21. I CERTIFY that death occurred on the date above etajed; that I attended august 45 19. 46 to Marc	deceased from	
2.02.000.001000010100000000000000000000			c) If alive, give ageyear	and that I last saw h alive on Monch		
7. Birth date of deceased (mo., day, y	o Mar	ch 4,	1892			
8. AGE: Years		Days	If lese than one day	Immedia: cause of death when his william	6 weeks	
55	0	1	hrs min			
9. Birthplace Eglon, Tucker, W. Va. (Town, county, and atate)			VA.	Oue to pulmonos the	4 months	
10. Veual occupation	Foreman					
11. Industry or business	Celanese	Corp.	of America	Oue to		
11. Industry or business Celanese Corp. of America 12. Name				Other conditions		
12. Name		Lou, W				
	Emm			(Include pregnancy within 3 months of death)		
14. Malden name.		***	***************************************	Major findings of operations.		
S. Birthplace	Masontown	Le We Vi	a	Date of op.		
16. Informant	Villard F.	Straws	ser	Autopsy results		
	6. Cumber	land.	id.	PHYSICIAN: Please underline the cause to which death should be cha	arged statistically.	
				22. VIOLENCE: If death was due to external causes, fill in the following:		
17. Buri	or removal. Which?	Date ther	eof 3/8/47 (month) (day) (year)	Accident, eulcide, or homicide	***************************************	
Cemetery or cremato	Hill	Crest	Cemetery	Where did Injury occur?	(State)	
I B			Md.	Injured at home, farm, Industry, public place (where?)		
			Kight	Meane of Injury Injured at work?		
Address		land.		1 111-	MI	
1		_	0 + 1.11: M	23. SIGNATURE	.D. or other	
Date rec'd by re	81947	X.	Registra	Address 54 heeme 8/" Date sign	gned 3 -6 -47	

MAR 11 1947

B REATING

Correct age	Dr. Schindler MARYLAND STATE DE	PARTMENT OF HEALTH DE St., Baltimore PARTMENT OF HEALTH DE OF DEATH Reg. Dist. No
item of information carefully. In cor	1. PLACE OF DEATH: County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State County
ormat death	James Reese Swaner	3. (b) Social Security Number 705-10 - 8377
ING n of inf uses of	4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced Marrie d	MEDICAL CERTIFICATION 20. DATE OF DEATH. 1947, 21 1:40 P.
FOR BI	8.(6) Name of husband or wise. Alice Edith Van Meter Swaner 7. Birth date of deceased (ma., day, yr.) February 14, 1872 8. AGE: Years Months Days It less than one day 75 0 25 hrs. min.	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18. 47. to 19. 47. and that I last saw have allive on 19. 47. Immedia: cause of death DURATION
RESEFICIANK.	9. Birthplace Key set W, Va. (Town, county, and state) 10. Usual occupation Carmen's believed	Due to Shyriterne C. V. Missine Jeurs.
MA UNF	11. Industry or business W., M. Te. Te. 12. Name	Dither conditions
Address / 48 Wais St. Carly L. Date mercot Market (Burial, cremation, or removal, Which?)	Address/48 Waily St. Carly, w. Va. 17. Buria Date mercot March 11, 1947 (Burial cremation or removal, Which?) Date mercot March 11, 1947	Autopsy results
9-45-15 WRITE	Commetery or crematory Hillerest Come terry Location Comment of Lond Md 18. Funeral director for Lond Hoffen	Where did Injury occur?
VS A15 PLEASE	19. March 11, 1947 J. Franklin, M. A. (Date rec'd by registrar)	23. SIGNATURE BY M. D. or other Address 44. Sales St. 4. Bate signed Mark 19447



PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly

WRITE

PLEASE

VS A15

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH: Ceunty Allegany City or fewn. Cumberland (If outside city or town limits, write RURAL and give nearest town) Hew long in above place of deaths, or street address where death occurred: 451 Henderson Ave. How leng in hespital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infanta give residence of mother) State. Maryland Ceusty Allegany City er town. (If outside city or town limits, write RURAL and give nearest town) Street No. 451 Henderson Ave. (If rural, give LOCATION) 2.(a) If veteran, name war.
3.(a) FULL NAME Bridget Anne Trenent	3. (b) Social Security Number
4. Sex 5. Celer or race 6.(a) Single, married, widewed, er diverced Female White Widowed	MEDICAL CERTIFICATION 20. DATE DF DEATH. Mar. 22, 19. 47. 21.0:A
6,(b) Name of husband or wife William Trenent 6.(c) If alive, give age years 7. Birth date of deceased (me., day, yr.) 8. AGE: Years Months Days It less than one day 65 11 19 hrs. min. 9. Birthplace Wheeling W. Va. (Town, county, and atte) 10. Usual occupation Housewife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. te. 22. 19. and that I last saw h 2. allve en
12. Name John Corrigan 13. Birthplace Ireland 14. Maiden name Filbin 15. Birthplace Ireland 15. Birthplace Ireland 16. Birthplace Ireland 17. Birthplace Ireland 18. Birthplace Ireland Ireland 18. Birthplace Ireland Irelan	Other conditions
Address 451 Henderson Ave. Cumberland, Md Burial (Buriat, cremation, or removal, Which?) Cemetery er crematery. HillCrest Burial Park	Antapsy results
Lecation Cumberland, Md. 18. Funeral director Charles L. George Address Cumberland, Md. 19. March 25, 1947 J. P. Traukhu M. D., Registrar	Injured at heme, farm, industry Public place (where?) Means of Injury Injured at werk? 23. SIGNATURE M. D. or other Address. Date signed

APR 1 1917 BUREAU V A

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correct age

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATI

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11 N. Charles St., Baltimore	(56%
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1. PLACE OF DEATH: Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infanta give residence of mother)
City or town. Cumberland (If outside city or town limits, write RURAL and give nearest town)	state Maryland County Allegany
How long in above place of death? 7 days	(If outside city or town limits, write RURAL and give nearest town)
Hospital, Institution, or street address where death occurred: Allegany Hospital	Street No. Columbia St.
How long in hospital or institution? 7 da.	(If rural, give LOCATION) 2.(a) It veteran, name war
3. (a) FULL NAME	
	3. (b) Social Security Number
Sarah Jane Turley 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
Female White Married	20. DATE OF DEATH March 3, 19 47 at 6:501
B.(b) Name of husband or wife Harry Turley 5.(c) If alive, give age year.	21. I CERTIEY that death occurred on the date above stated; that I attended deceased from 2. 3. 19.47. to
deceased (mo., day, yr.) Sept. 10,1877	Immediate cause of death DURATION
8. AGE: Years Months Days It less than one day	in. Septer Cufretion I was
9. BirthplaceStraffordshire, England	Due to Selection not due to can with
1D. Usual occupation. Housewife	Due to Comment of the
11. Industry or business	Due to Colypus in colons
Samuel Snelson 12. Name Samuel Snelson England	Bther conditions Australia
	(Include pregnancy within 3 months of death)
14. Maiden name Harriet	Major findings of operations.
15. Birthplace England	— Date of op.
16. Informant Mr. Harry Turley	Antoney results.
Address Columbia St. Mt. Savage, Md.	PHYSICIAN: Please underline the cause to which death should be charged statistically.
17 Burial (Burial, cremation, or removal. Which?) Date thereof March 6, 1947 (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or crematory St. George Episcopal	Where did injury occur?
Location Mt. Savage, Md.	
18. Funeral director Charles L. George	Meens of Injury injured at work?
Address Cumberland, Md.	4-11/2 C/1000-100
m. 1 = 10 P = 10 · m)	23. SIGNATURE M. W. C. or other

UNFADING INK. Supply every item of information carefully. The cant. Physicians: please write the causes of death clearly and legibli MARGIN RESERVED FOR BINDING PLEASE WRITE PLAINLY,

important.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore 932

Reg.	Diat.	No.

02402 at. No. 240

1. PLACE OF DEATH: COUNTY Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
Cily or town	State Maryland County Allegany		
(If outside city or town limits, write RURAL and give nearest town)	City or town Cumberland Rural (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?			
Allegany Hospital	Sireet No. 16 Klostermans Addition		
How long in hospital or Institution?	2.(a) If veteran name war		
3. (a) FULL NAME	3. (b) Social Security Number		
Elizabeth M. Turner 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
Female White Widowed	20. DATE OF DEATH Meanel 5 1947, 21 A		
6.(b) Name of husband or wife. Barthomelow Turner	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from		
7. Birth date of	and that t last saw halive on		
deceased (mo., day, yr.) Oct. 1, 1872	Immedia: cause of death Well o Councillo OURATIO		
8. AGE: Years Months Days If less than one day	arteris clusis.		
74 5 4hrsmin.			
9. Birthplace Philadelphia, Penna. (Town, county, and state) 10. Usual occupation Housewife	Oue to		
11. Industry or business 12. Name	Diher conditions		
13. Birthplace Scotland			
	(Include pregnancy within 3 months of death)		
14. Malden name Mary Gilsten 15. Birthplace Scotland	Major findings of operations.		
15. Birthplace Scotland			
16. Informant Mr. Joseph P. Turner	Autopsy results		
Address 16 Klostermans Addt. Cumberland	PHYSICIAN: Please underline the cause to which death should be charged statistically.		
	22. VIOLENCE: If death was due to external causes, fill in the following:		
Burial (Burial, cremation, or removal, Which?) Oate thereof Mar. 8, 1947 (month) (day) (year)	Accident, suicide, or homicide		
Cemetery or crematory New Cathedral Cem.	Where did injury occur? (City or town) (County) (State)		
Location Philadelphia, Penna.	Injured at home, farm, industry, public place (where?)		
18. Funeral director. Charles L. George	Means of Injury Injured at work?		
0. 23 Ma	and with a		
	23. SIGNATURE M. D. or other		
19 March 5 19 47 Jankhi M.L	1- (2) 101 1 (11) 3/5/2		
(Date rec'd by registrar) Registrar	Address Date signed		

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VS A15 9.45.15M



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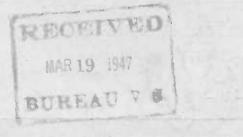
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02403 Reg. Diat. No. 40

/			
1. PLACE OF DEATH: CountyALLICANY	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State		
City or town			
How long in above place of death?	City or town MTDLAND (If outside city or town limits, write RURAL and give nearest town)		
	Street No.		
MIMORIAL HOSPITAL	(If rural, give LOCATION)		
How long in hospital or Institution?	. 2.(a) If veteran, name war.		
3. (a) FULL NAME	3. (b) Social Security Number		
MRS HMMA WACHTS	Nove		
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
FEMALE WHITE WIDOW	20. DATE OF DEATH		
6.(6) Name of husband or wife	19 70 10 20 19 7		
7. Birth date of	and that I last saw h. A allye on		
deceased (mo., day, yr.) 3-29-79	Immediate space of death		
8. AGE: Years Months Days If less than one day			
67 11 /3hrsmlr	(Source D/ nemour		
8. Birthglace	Oue to		
10. Usual occupation 14 vuserousk			
11. Industry or business Censon home	Due to		
	Other conditions A. L. L. Appartiop has		
12. Name	1 1 2 1 1 1 1		
	(Include pregnancy within 3 months of death)		
14. Maiden nameP.ENDEGRASS	Major findings of operations.		
	Date of op.		
18. Informant Mas Mary Cerowe	Autopsy results.		
Address Midland and	PHYSICIAN: Please underline the cause to which death should be charged statistically.		
17. Buna al Date thereof MAN 15. 194 (Burial, cremation, or removal. Which?)	22. VIOLENCE: tf death was due to external causes, fill in the following; Accident, suicide, or homicide		
Cemetery or crematory allegassy Leinetery	Where did injury occur?		
Location throstlying ond.	tnjured at home, farm, Industry, public place (where?)		
18. Funeral director Mainhown	Msans of Injury Injured at work?		
	1 7 / Vica.		
Address Jaconing, 400.	23. SIGNATURED M. D. or other		
19 March 15, 1947 St. Wanklin, M.			
(Date rec'd by registrar) / Registra	Andrew Land Bate signed 3/4		



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MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

		CERTIFIC	ATE OF DEATH	Reg. Dist. No	40
City or town	Llegany Limberland ide eity or town limit leath? Let address where dea Llegany H	s, write RURAL and give nearest town) h occurred: ospital	2. USUAL RESIDENCE (HOME) OF (For newborn infants give residence of state Maryland Council City or town Route 4, North (If outside city or town limits Street No. (If rural, give 2.(a) it veteran, name war.	mother) anty Allegany th Branch s. write RURAL and give nearest Md. LOCATION)	
3. (a) FULL NAME		6		3. (b) Social Security Nu	mher
3. (d) 1022 min	BE	TTIE SUE WHARTON		Maria	2001
4. Sex 5.	. Color or race	6.(a)Single, married, widowed, or divorced	MEDICAL CI	ERTIFICATION	-
Female	White	Single	20, DATE OF DEATH 12 March		6.15
deceased (mo., day, yr.) 8. AGE: Yeara 2	4 May 19 Months 10	6.(c) If alive, give age	Immedisie capte of death afficient a films films a films films a	ia ki got upper	DURATION 5
9. Birthplace			Due to		
12. Name Char	ryland		Other conditions	months of death)	
14. Maiden name	Sylvia Ro Maryland	yer	Major findings of operations	Pole of an O	م ر
16. Informant Charles Wharton Address Route 4, Cumberland, Md.			PHYSICIAN: Please underline the cause to w	hich death should be charged stat	tistically.
(Burial, cremation, or	Food ash	Date thereot (month) (day) (year)	22. VIOLENCE: If death was due to external cau Accident, suicide, or homicide	Date of	State)
		.Va.		Injured 1 work?	
18. Funeral director	Cumberlan		Kan I	do NA	1

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Diat. No. .

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County 17/1egd 114	State W. Va County Mineral
City or town (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? 2 day 5	(If outstee city or town limits, write RURAL and give nesrest town)
Hospilal, institution, or street address where death occurred:	Street No. 528 Newton St.
Memorial Hospital	(If rursi, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b), Social Security Number
Kotherine Mobel Whet	zel 7/pil
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
F W single	,
	20. DATE OF DEATH
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(c) If alive, give ageyears	10 mm 19 4) 10 12 mm 19 4
7. Birth date of	and that I last saw h.R.Calive on
deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day	Immediain cause of death
0 0 7hrsmin.	Orematurity.
2 / / / 1 2/	
9. Birthplace Com berland Md. (Town, county, and state)	Due to
10. Usual occupation	Due to
11. Industry or business	>
12. Name Paul Whetzel	Other conditions Almandagia Rusal
13. Birthplace Peters burg, W, Vo.	(Include pregnancy within 3 months of death)
# 14. Maiden name Madeline Bradfard	(Include pregnancy within a months of death) Major findings of operations
15. Birthplace Magreyfield, W. Va.	Dale of op.
16. Informant Mr. Paul Whylis Il	Autopsy results
Address Deusev, W. Va .)	
17. Burial, cremation, or removal. Which?) [Burial, cremation, or removal. Which?] [Burial, cremation, or removal. Which?]	22. VIOLENCE: If death was due to external causes, fill in the following:
	Accident, suicide, or homicide
Cemetery or crematory Philos Cemetery	Where did injury occur? (City or town) (County) (State)
Location Western part, 17d	Injured at home, farm, industry, public place (where?)
18. Funeral director Atlanta La Holan	Means of Injury Injured at work?
Address Cheerlandland, rud.	23. SIGNATURE Fuller B Mutwart
The state of the sun	23. SIGNATURE JULIA M. D. or other
19 March 13 19 47 J. P. Mauklin, M. h.) (Date ree'd by registrar)	Address 112 Bestind 8t Date signed 12 Many



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother)
	State Md. county Allegany
City or town Frostburg Md. (If outside city or town limits, write RURAL and give nearest town)	City or town. Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 15 minutes	
Rospilal, institution, or street address where death occurred: Miners Hospital	Street No. 182 W. Main St.
How long In hospital or Institution? about 15 minutes	2.(a) If veteran, name war.
3. (a) FULL NAME	3. (b) Social Security Number
Clarence Edward Whitacre 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
male white Widowed	
male white Widowed.	20. DATE OF DEATH. March 22 19 47, at 9 A M
6.(b) Name of husband or wifeEvaBlocher	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7. Birth date of	and that I last saw h im Dead March 22 19.47
7. Birth date of deceased (mo., day, yr.) Nov. Ist. 1878	Immediate cause of death Fracture of the 3rd DURATION
8. AGE: Years Months Days It less than one day	cervical vertebrae linear frac about
68 2 2Ihrsmin.	ture of skull & concussion of half
9. Birthplace Peach Bottom, Pa. (Town, eounty, and state)	but brain hour
10. Usual occupationButcher	Due to Hit by an automobile
11. Industry or business	DUE TO THE TOTAL TO THE OFFICE OF THE OFFICE OF THE OFFICE OF THE OFFICE
	Other conditions Fractures of nose, left
12. Name George Whitaker 13. Birthplace Unknown	leg above ankle &right femur (Include pregnancy within 3 months of death)
14. Malden name Lacey Ann Unknown	Major fiudiugs of operations
	Date of op.
t6. Informant Miss Edna Whitaker	Autopsy results
Address I82 W. Main St. Frostburg, Md.	22. VIOLENCE: If death was due to external causes, fill in the following:
17. Burial Date thereof Mar 25th 14 (Burial, cremation, or removal. Which?)	accident 3.22.1947
	where did injury occur? Frostburg Allegany Md. about 1/8 mi (Chypteth of R. F. D. 46 Frostburg Injured at home, farm, Industry, public place (where?) Snow
Cemetery or crematoryJohnsonsCemetery	about 1/8 mi chorth of F D 46 Frostburg
Locatio Route 40 Highway, Frostburg, Md.	Injured at home, farm, Industry, public place (where?) Show Means of Injury Auto. Skidded Onlinjured at work? going to
18. Funeral director Jacob Hafer	Means of injury Auto. Skladed Offinjured at work? going to
Address Frostburg, Md.	
	23. SIGNATUREH. V. Deming M.D. H. V. Deming M.D.
19.3-24 (Date rec'd by registrar) 1947 Muss. Maurcy N. Kde	Address balland md Date signed 3-12-1947.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 917

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CERTIFICAT	E OF DEATH Reg. Diat. No.
County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland County Allegany City or town Cumberland, (If outside city or town limits, write RURAL and give nearest town) 213 S. Spruce St., (If rural, give LOCATION) 2.(a) If veteran, name war
3. (a) FULL NAME SANDRA KAY WILKINSON	3. (b) Social Security Number None
4. Sex Female S. Color or race S.(a) Single, married, widowed, or divorced Single	MEDICAL CERTIFICATION 20. DATE OF DEATH. Mar. 22, 1947 21 1:00P.
8. A.G.E. Years Months Days tf less than one day	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 to March 2 9 9 % and that I last saw h
1 5 28 hrs. min. S. Birthplace Cumberland Allegany Maryland (Town, county, and state) 10. Usual occupation Infant 11. Industry or business	Oue to
13. Birthplace Cumberland, Md.	Other conditions
Mr. Ralph E. Wilkinson Address 213 S. Spruce St., Cumberland, Md	Antopsy results PHYStCtAN: Please underline the cause to which death should be charged statistically.
Burial Date thereof Mar. 25, 1947 (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory Hill Crest Cem.	22. VIOLENCE: If death was due to external causes, till in the following; Accident, suicide, or homicide
Cumberland, Md. 18. Funeral director. Charles L. George Address Cumberland, Md.	Injured at home, farm, industry, public place (where?) Meens of Injury Injured at work?

MARGIN RESERVED FOR BINDING

UNFADING INK. Supply every item of information carefully. The cant. Physicians: please write the causes of death clearly and legibly

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information carefully. The of death clearly and legibly

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MARYLAND STATE DEPARTMENT OF HEALTH

11 N. Charles St., Baltimore 932



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(State)

CERTIFICATE OF DEATH

1. PLACE OF DEATH: County Allegany County County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
City or town. CumperLand. M.C. (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?	State M	
3. (a) FULL NAME	3. (b) Social Security Number	-
Miss Emma Willison	None	
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced Female white single	MEDICAL CERTIFICATION about 20, Date of Death March 25	out
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19	4.7
8. AGE: Years Months Days If less than one day 8. Birthplace MACCA (Town, county, and state)	Immediai, cause of death DURA Se ve Se ve Se to	
10. Usual occupation	Due to	
12. Name Asabel Millison Scotland	Other conditions Arterio sclerosis	
14. Maiden name Amonda Bryan 15. Birthplace Actland	(Include pregnancy within 3 months of death) Major findings ol operations. Date of op.	
Address Organiesland md.	Autopsy results	
B. : 0 Charles 47	22. VIOLENCE: If death was due to external causes, fill in the following:	

WITH UNFA especially PLAINLY, is especially 17 Omisk (Burial, cremation, or removal, Which?) WRITE

Address

(City or town)

Accident, suicide, or homicide,.....

Injured at home, farm, Industry, public place (where?)

Where did injury occur?

Meane of Injury

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-4)

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CERTIFICATE OF DEATH				
PRILLIE AIR TH THATH		PTA	Les A A	A PETE E
	PRI		P 1)P/	2 I H

Reg.	Dist.	No.	6	

county	(For newborn infants give residence of mother)
Cily or town. (If outside city or town limits, write RURAL and give nearest to	State will y Little County
How long in above place of death?	(If outside eity or town fimits, write RURAL and give nearest town)
Hospital, Institution, or street address where death occurred:	Street No. Green St.
Green St.	(If rural, give LOCATION)
How long in hospital or institution?	2.(a) If veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
Daniel Floyd Wilt	220-10-2696
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorcet	WEDICAL CERTIFICATION
Male White Married	20. DATE OF DEATH MARCH 19 19 27 21 5:45pm
6.(b) Nams of husband or wifs. Aldie Mae wilt	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 19.4.7 10. March 19.4.7
7. Birth date of Nort 30 3003	and that I last saw he alive on March 19 19.4.7
7. Birth date of deceased (mo., day, pr.) NOV 19, 1881	Immedia cause of death ID DURATION
8. AGE: Ysars Months Days If less than one day	Immedia couse of death thombacic 5 days.
65 4 0hrs.	min.
9. Birthplace	Land Due to Central an few of clusies
10. Usual occupation Watchman	
IX D A	Due 10.
	Diher conditions Ly Mr. fews in
	(Include pregnancy within 3 months of death)
14. Malden name Sarah Ellen Wilt 15. Birthplace Maryland	Major findings of operations
	Date of op
16. Intermant Winnie Wilt	Autopsy results
Address Westernport, Maryland	
17. Rurial (Burial, cremation, or removal. Which?) Oate thereot. March 23. (month) (day)	7 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or crematory Philos Cemetery	
Westernport, Maryland	Injured at home, farm, industry, public place (where?)
18. Funeral director Fllsworth S. Boal	Msans of Injury Injured at work?
Address Westernport, Maryland	Therman treeses Tu, N
6 - Alexander O	23. SIGNATORE. M. D. or other
(Date ree'd by registrar)	Registrar Address Cutury w & M. Date signed 3. 22 4 /

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICAT	E OF DEATH Reg. Diat. No	
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
County Alfly The property of	State. D. d County Allegarsas	
City or town	1 / / / / / / / / / / / / / / / / / / /	8
How long in above place of death? 2 whi -	(If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred:	Street No. 15 (Arural, give LOCATION)	******
How long in hospital or institution?	2.(a) It veteran, name war	
3. (a) FULL NAME	3. (b) Social Security Number	
mo Loude S. Ha	alet None	
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
Female White Mounts	20. DATE OF DEATH 11 March, 19 47 316:00	A C
6.(b) Name of husband or wite Land V. Minglet	21. I CERTIFY that death occurred on the date above stated; that I attended disceased from	
O.(C) Hallie of Hassania of Miles	21 February 19 47 toll March 19	
7. Birth date of deceased (mo., day, yr.) Qual 13 - 1885	and that I last saw h. e.r. allve on 11 March 18:	
8. AGE: Years Months Days It less than one day	Immediate cause of death Chronic nephritis OURAT with terminal uremia.	IDK
6/ 8 28hrsmin.	WI OII OCIMIIICA GI VIII O	************
I say inte Oronge affect hid.	Queta Chronic choleystitis 3 mo	S.
9. Birthplace (Town, eounty, and state)		
10. Usual occupation	Due to Chronic Hepatitis 3 mo	S.a
11. Industry or business		
12. Name Va 13. Birthplace	Other conditions	
	(Include pregnancy within 8 months of death)	
14. Maiden name of any and the Shall and the State of any and the state of the stat	Miniot Indiana of obcienos	all
\$ 15. Birthplace Ocasto M. Maj	bladder and liver. Oate of op. 7 Mar. 1	94.7
16. Interment Charles 16. Waghers	Autopay results	
Address P. Lo. #1 Frestlyg, nd	22. VIOLENCE: If death was due to external causes, till in the tollowing:	
(Burial, cremation, or remoyal. Which?) Quite thereof (month) (day) (year)	Accident, suicide, or homicide	
	Whars did injury occur?	
1 1 7	Injured at home, farm, Industry, public place (where?)	
Location A. O. Land A. Market g	Means of injury Injured at work?	
18. Funeral director	1	
Address Atesting, Mill	23. SIGNATURE. W. OUGLO W. D. or other	411
19 March 13 19 47/ J. P. tranklin, M. D. Registrar	110 S Centre St. 13 Mar	rch
(Date rec'd by registrar) Registrar	Address Date signed Date signed	

FOR BINDING RESERVED MARGIN WITH UNFADING INK. Supply every item of information carefully. The important. Physicians: please write the causes of death clearly and legible

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MAR 19 1947

Wattin a rporate limits MARYLAND STATE DEPARTMENT OF HEALTH 2411 N. Charles St., Baltimore CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: County allo and (For newborn faints give residence of mother) information carefully. The of death clearly and legible City or town How long in above place of death?.. Hospital, Institution, or street address where death occurred: (If rural, give LOCATION) How long in hospital or institution?.. 2.(a) If veteran, name war..... 3. (a) FULL NAME 3. (b) Social Security Number MEDICAL CERTIFICATION causes FOR BINDING 20. DATE OF MEATH 21. I CERTIFY that death occurred on the date above stated: that attended deceased from 6.(c) If alive, give age te 7. Birth date of deceased (mo., day, yr.) If less than one day Years 8. AGE: RESERVED 10 d 10. Usual occupation MARGIN 11. Industry or business important. 13. Birthplace (Include pregnancy within 3 months of death) 14. Maiden name. Major findings of operations..... 15. Birthplace especially 16. Intermant PHYStCIAN: Please underline the cause to which death should be charged statistically. PLAINL Address 22. VIOLENCE: If death was due to external causes, till in the following: Accident, suicide, or homicide..... (Burial, cremation, or removal, Where did injury occur? WRITE (City or town) (State) (County) injured at home, farm, industry, public place (where?) ... Meens of Injury Injured at work? 1B. Funeral director Address 23. SIGNATURE. Registrar | Address.

- Section for The Sand see 320 Mestimore Con ence sand Eugenia Winglet - your Frank What water of ward to moved so there apr 20 See Lind all 2 2 d refut remak RECEIVED B REAL 3 17-35: Sut 200 Counterland Int